international journal of health education

In this issue:

Programme of the Dusseldorf Conference

Health Education through Biology

The Braintree Experiment

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The Importance of Programme Planning

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VOL. II No 2 APRIL 1959

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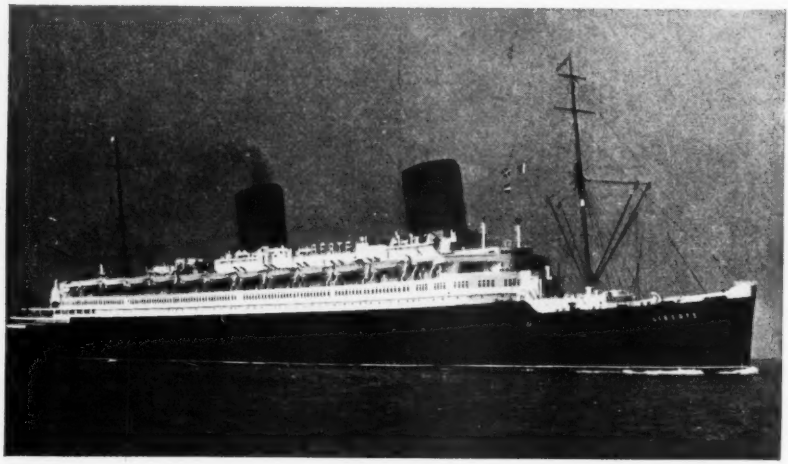

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VOL. II No. 2 APRIL 1959

international journal of health education

...A work of Civilization and Peace — Lucien Viborel 59

Programme of the Dusseldorf Conference 60

Health Education Through Biology — Frank Tyrer 63

We Built a Community Bath and Washhouse — Pedro T. Orata 70

The Braintree Experiment — Frank St. D. Rowntree 73

Could You Have Done This? — Janus 80

Training in Health Education — A Challenge — John Brotherston 82

Health Education by TV in Saudi Arabia — Mitchell V. Owens 87

Learning to eat — the right way 93

The importance of Programme Planning — Guy Steuart 94

USSR: The Health of the Workers — L. Bogolepova 100

WHO Panorama 102

IUHEP News 103

Books 104

Films and Visual Aids 108

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" *Healthier teeth for all, thanks in part to public relations*

How we told them to clean their teeth...

Less than 50% of German children brush their teeth regularly. Dental decay is at an all time high. A committee has been formed to start a national public health campaign. Progress so far: in some areas up to 10% increase in toothbrushing. Here is how they are doing it: State Health Weeks are planned by representatives from education, dentistry, government and industry. These "Saturation campaigns" are launched by massive distribution of pamphlets, posters, display cards as well as by lectures and movie shows. To make the campaign real and lasting, each firstgrader is given a handsomely wrapped kit containing all he needs for oral hygiene. Press releases, imaginative radio and TV reports and interviews keep interest alive. More dental hygiene weeks are planned for the future.

For further information and for examples of the material which has been exclusively produced for this campaign, please write to

VEREIN FÜR ZAHNHYGIENE E.V.
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...a work of civilization and peace

The International Union for Health Education of the Public will hold its IVth Conference in Dusseldorf, the 2-9 May, 1959.

Leading experts and technicians in such varied fields as medicine, hygiene, psychology, pedagogy, sociology, health education and social welfare will meet on this occasion. Unlike in Rome, where the IIIrd Conference provided the opportunity to exchange views on general principles, concepts and methods of health education the Dusseldorf meeting will highlight and allow for detailed study, of one specific problem: the health education of children and youth. The importance of this problem which concerns humanity's most precious pledge for the future is self evident, and the wide spread interest inspired by the Dusseldorf Conference confirms the appeal of the theme selected. Both at plenary sessions and in the twenty study groups of the Conference, it will be discussed under the most varied aspects: role of health education in promoting the physical, mental and social health of the child, child health problems in the world of today and tomorrow, the role played by youth organizations, the contribution of sport and recreation in the health education of children and youth, etc.

The IVth Conference is a logical continuation of the Rome gathering which represented a milestone in the progress of health education and gave a strong impetus to the Union's development.

Organized by the German Federal Committee for Health Education, the Conference will take place in the Congress Palace of Dusseldorf, an intellectual, artistic and industrial centre which enjoys a great tradition of hospitality.

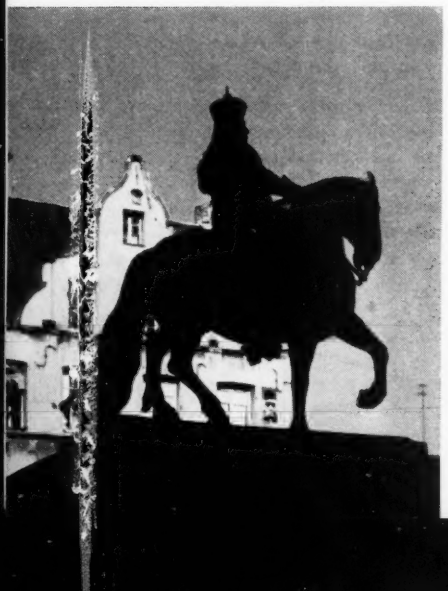
An Exhibition of Technical Means and the Selection of Films will contribute to the interest of the study sessions.

Receptions and excursions have been planned to give additional pleasure to a stay in Dusseldorf during the most pleasant season of the year, the season of light, warmth and spring flowers.

Doctors, chemists, educators—more particularly health educators —anthropologists, social workers, hospital technicians, all the men and women active in the vast field of medicine, health, education and social welfare are cordially invited to participate in the Conference and to contribute their experience and ideas to the development of the International Union for the Health Education of the Public, whose efforts aim not only at the harmonious promotion of health but constitute a work of civilization and peace.

Lucien Viborel

The Rheinhalle where the inauguration ceremony of the Conference will be held on Sunday 3 May; below, Dusseldorf's famous statue of Jan Wellem



Sunday, 3 May

11:00 a.m. Opening Ceremony

Addresses

Dr. V. STEINBISS, Member of Parliament
President of the German Federal Committee for Health Education of the Public

Dr. E. GERSTENMAIER,
President of the Parliament of the Federal Republic of Germany

Dr. G. SCHRÖDER,
Minister of the Interior of the Federal Republic of Germany

Mr. G. GLOCK
Mayor of Dusseldorf

Prof. G. L'ELTORE,
President of the International Union for Health Education of the Public

Representatives of the United Nations and of international organizations

3:00 p.m. Sightseeing tour of Dusseldorf

Monday, 4 May

9:00 a.m. Opening of the Health Education Exhibition by the President of the German Federal Committee for Health Education of the Public

10:00-11:30 a.m. Plenary Session:

Addresses:

Min.-Dir. Dr. STRALAU,
Director of the Health Department of the Ministry of the Interior, Federal Republic of Germany
" Health Education of Youth "

Dr. B. GANICKY
Central Institute for Health Education, Prague, Czechoslovakia
" The Role of Health Education for School Age Children and Adolescents and the Preparation of Teachers and Doctors for this Task "

Dr. J. BURTON
Health Education Specialist, WHO Headquarters, Geneva
" International Aspects of Health Education "

11:30 a.m. Appointment of study groups

3:00-6:00 p.m. Study group sessions

Tuesday, 5 May

9:00-12:00 a.m. Plenary Session

Addresses:

Prof. C. E. TURNER,
Professor of Public Health Emeritus, Massachusetts Institute of Technology, USA, Chief Counselor of the IUHEP

" Cooperation among Voluntary Health Organizations "

Prof. L. BOGOLEPOVA,
Director of the Central Institute for Health Education, Moscow, USSR

" The Role of Health Education in Promoting the Physical, Mental and Social Health of Children and Youth "

Dr. K. SODDY,
Scientific Director of the World Federation for Mental Health,

" Health Education and the Mental Health of Children "

3:00-6:00 p.m. Study group sessions

Wednesday, 6 May

9:00-12:00 a.m. Plenary Session

Addresses:

Dr. G. FEHR
Chairman of the Junior Red Cross Advisory Committee of the League of Red Cross Societies, and Director of the German Junior Red Cross, Bonn, Federal Republic of Germany

" Health Education of German Youth "

Mr. W. H. WELLING,
Department of Education, Unesco

" Commentaries on the Discussion Topics of the IVth International Conference "

Dr. H. DÖPP-VORWALD,
Professor at the University of Münster, Federal Republic of Germany

" Educational Aspects of Health Education "

3:00-6:00 p.m. Study group sessions

8:00 p.m. Reception by the Prime Minister of North-Rhine Westphalia on the Rheinterrassen

Thursday, 7 May

9:00-10:00 a.m. Plenary Session

Report of the Chairman of the IUHEP Standing Committee on Research

Dr. M. DERRYBERRY,
Chief, Public Health Education Services, US Public Health Service, Washington, USA

Thursday, 7 May *(ctd)*

Report of the Chairman of the IUHEP Standing Committee on Professional Training in Health Education

Dr. H. LEAVELL,
Professor of Public Health Practice, Harvard School of Public Health, Boston, USA

10:00-12:00 a.m. Study group sessions

3:00-6:00 p.m. Continuation of study group sessions

8:00-10:00 p.m. Public presentation of films

Friday, 8 May

9:00-12:00 a.m. Plenary Session

Study group reports and discussion

3:00-5:00 p.m. Continuation of study group reports

6:00-7:00 p.m. Puppet show

8:30 p.m. Banquet on the Rheinterrassen

Saturday, 9 May

9:00 a.m. Closing Session of the Conference

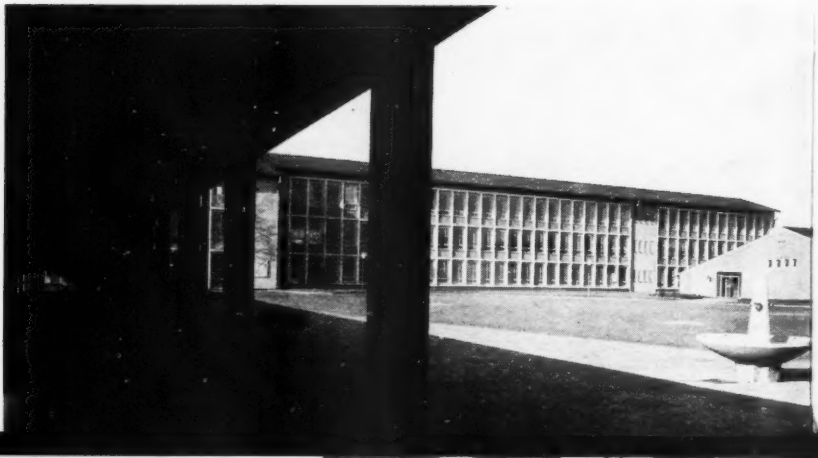
Reports of the Jury for the Exhibition and of the Jury for the Selection of Films; distribution of prizes

10:30 a.m. General Assembly of the IUHEP

3:00-7:00 p.m. Visits to scientific, educational and welfare institutions

Daily 3:00-7:00 p.m. Presentation of films (small Kongressaal)

The Caecilienschule, in Dusseldorf Oberkassel, will be host to the Conference study groups



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Health education through biology

Do you remember when you were a child learning at school about the blood system? It was fascinating, BUT... But did it equip you with practical health knowledge? Was the teaching related to your life or that of your community?... Integrating health education in the teaching of biology, helping the children to prepare for real-life problems and to think for themselves—such is the challenge to which the author has devoted 20 years of experimenting.

by Frank Tyrer

In 1929, with a degree in chemistry, physics and mathematics, I began to teach science to children of 11 plus in what we call now a secondary modern school *. As was customary my science scheme consisted mainly of physics with a little chemistry. About this time there was a feeling amongst educationists that this was not enough; that science schemes should also include some biology, and this was usually interpreted as meaning botany and zoology, or perhaps human physiology, or in rural areas as rural science. I had only been teaching about six months when it was suggested to me that I should introduce into my work elementary human physiology. This I did. Very soon, however, I realized that this was far from satisfactory.

Something seemed wrong

I felt there was something lacking in a course which just gave the children facts and was in no way related to the life of the child or the community in which it lived. I therefore visited a number of schools to see what other science teachers were doing, and found them doing exactly the same thing—teaching physics and chemistry. A few did include some simple botany and zoology or were just giving the children some plain factual information about the working of the human body.

British born Frank Tyrer left elementary school at the age of 14—he had failed Great Britain's 11-plus examination which entitles successful candidates to Secondary Grammar School education.

Undaunted, he went to work and studied in the evenings at a technical college, to later take his M.A. and B.Sc. degrees at Liverpool University. He has been a teacher, mainly of biology, since 1926 and is at present Senior Science Master, Waterloo County Secondary School, Lancashire.

" Failing my eleven-plus was my greatest success ", he says. " At grammar school I would have studied botany and zoology and have thus been ' conditioned ' to teach these subjects. Because I failed I was not so ' conditioned ' and thus able to take the broader view of biology that has been the basis of my teaching ". He is the author of four books on biology. Frank Tyrer's self acknowledged hobbies are visits to Switzerland and studying local history.

In addition, I found the work in biology very often consisted of a series of unconnected lessons—one week the children were given a simple account of the skeleton, and the next week of the blood system. I saw little of value to children in such teaching. Neither did I see any value in teaching botany and zoology to children who were not training for one of the professions. Why was it thought necessary that a child who was going to be an engineer or an office worker should know all the detailed structure of a plant or animal?

At the same time I observed that little was being done in the way of health education beyond telling the children the importance of cleanliness and perhaps an odd lesson or two on the value of temperance.

The teaching should be concerned with man as a whole—not just give a series of disconnected lessons

Twenty years of experimenting

This dissatisfaction with the biology teaching and the health education given in schools led me to experiment in new ideas and new methods. For more than twenty years I tried out scheme after scheme, and idea after idea, and eventually there evolved what I believe to be a much more satisfactory method of teaching biology.

The two main problems were to relate the teaching in the school to the life and health of the individual and the community and secondly to give the lessons in a logical sequence.

It was obvious at once that the work would be more concerned with human biology than with botany and zoology. But it would not be concerned with man exclusively. That would be absurd in a world where the activities of man, animals and plants are so interdependent.

After several years of trying out new ideas and methods, I found it best to start off with a very simple study of the cells of which living things are built, and then go on to a study of the human framework, the skeleton. This will only be dealt with in a very simple manner; we are not training the children to be doctors and nurses. This will be followed by an extremely simple comparative study of the framework of one or two animals, mainly to show that vertebrates have a skeleton similar to ours, and to give a general idea of the differences between the framework of a vertebrate and an invertebrate. Now this framework needs something to move it, and so we come to a study of muscle and movement, movement in man, in animals and in

* At 11 years of age, children in the primary junior schools take a selective or scholarship examination. Those who pass go to secondary grammar schools to take an academic course leading to the universities or to entry into one of the professions, or to secondary technical schools to receive a technical education. Those who fail to pass go to secondary modern schools to receive a more general education.

plants. Muscles require energy to work and to obtain this energy living things must have food and oxygen. So now we make a study of food and digestion, and follow this with a study of oxygen and breathing. In dealing with plants the essential elements only of the requirements of plants and food-making in the green leaf in sunlight are considered. The oxygen and food and other things need to be transported about the living thing and so we now deal with the blood system or the transport system. During the production of energy and the building up and breaking down of cells waste substances are produced and thus we begin a study of the excretory system. By this means the children will realize that all the systems of the body are working together for the benefit and well-being of the living thing.

Man becomes the main concern

The great value of teaching biology with man as the main object of study is that it is so easy and so natural to introduce health education; a thing very difficult to do if the biology had just been interpreted as botany and zoology. Let us see how it can be done.

In the first year, the work in biology is just simply nature study, to link up with the nature study done in the primary infant and junior schools. We may say they are learning something of the "variety of life". In addition, some health education will be given, chiefly on matters of personal cleanliness. No set course is followed, but I seize upon any opportunity to discuss some point in hygiene. For example, I may notice that some of the boys or girls are looking very fit, very healthy, or particularly tidy and clean. I would comment on this and begin to talk on some of the ways in which we can keep healthy and fit.

After this first year, however, the health education will not be treated as a separate entity, but will arise naturally out of the lessons in human biology.

Spotlight on community life

In the second year, the children discover what is going on in a living thing; that is they are learning something about the "energy of life"—how living things are built, how they move, why they need food and oxygen, the transport system of the body, the problems of getting rid of waste and keeping warm.

In the third year, the children study those processes which are mainly responsible for helping living things to go on living. They discover what directs and controls all that is going on in a living thing and how living things get to know and respond to what is happening inside and around about them. They also learn something about the ways in which living things reproduce, develop and grow, and how new types of living things may arise.

During these two years the health education arises quite naturally out of the biological work, of which it forms an intrinsic part.

In lessons on breathing, for example, I do not just deal with the questions of why and how we breathe, but I discuss with the class the problems of smoke and smoke abatement, and breathing air in workshops where injurious dusts and fumes might endanger the health of workers.

When discussing excretion, I do not just talk about how waste is produced in the body and the ways in which we excrete this waste; I do not just give the bare facts of getting rid of waste; that is not enough. I now show the children how it is linked up with personal health and the health of the community. We talk about the necessity for washing the

hands after using the toilet and before a meal, and the importance of keeping the toilet clean. We discuss the problems that arose when man began to live in large communities; the problem of the disposal of refuse and sewage. We go out and see what our town does about the disposal of waste and talk to the people responsible for this side of public health work.

In lessons on the framework of our body, I give a very simple account of its structure. I do not bother the children with the names of the bones nor their number, but I am very much concerned that they should learn how they can build up good bones by eating foods with calcium and vitamin D in. And here I explain why giving of free milk in our schools has been one of the factors leading to the better health of the children of today. I am anxious that they should know what is being done to prevent rickets; that they should know of the good work carried out in the maternity clinics and infant welfare clinics. I am keen that they should know how sunlight can help to build up good bones and therefore how important it is to clear away slum dwellings and build better houses with more window space and garden space and towns with wider streets and more open spaces.

This is real biology; social or human biology. This is sound health education; health education which is not a separate subject in the curriculum, but forms an integral part of the work in biology.

"Biology in the service of man"

Thus after the first year, the health education arises quite naturally out of the biology, provided it is given as human biology. By the time the children enter their fourth and final year it is hoped they will have a good foundation of biological knowledge and are now ready to make a study of "Biology in the service of man", and here health education on a broad scale will form an important feature of the work.

Now they will learn how man's discoveries in biology and science generally are used for the benefit of mankind. In this final year we study such topics as: bacteria and their work, battle for health, health and the community, fighting disease in plants and animals, biology and agriculture, more about the foods we need, biology and industry, and biology in the home.

The children will discover how biological knowledge is or can be used to improve the health of human beings and lead to the greater happiness of mankind everywhere. They will find out what is being done or could be done to improve the living conditions of man, animals and plants. They will make a study of bacteria so that they can understand more clearly how man fights against disease in himself, in animals and in plants. They will learn how biological knowledge is used to maintain and improve the health of the communities in which man lives and to improve the conditions in which man works. They will find how biology is applied in agriculture to produce better plants and animals and to increase the world's food supply. And since the great majority of these senior children in a few years' time will be thinking of marrying, they will learn how a knowledge of biology will help them to make their home healthy and happy.

Setting them to think for themselves

This work with senior children: the teenagers who are on the verge of entering the world outside the school walls—the office, the factory, the shop—offers a

tremendous challenge to the health educationist and teacher, and at the same time enables them to feel they are doing something to make the world a better place for mankind. These senior children are now beginning to think more for themselves; they are being confronted with new problems, and the health educationists and teachers have to decide how best they can help them.

The methods used in teaching social or human biology with the senior children of 14 to 16 years in the secondary modern school will depend upon a number of factors: the time allowed for biology in the curriculum, the intelligence of the children, and on how far the children have progressed in biology in the preceding years. Generally, I find the work is done by the ordinary lesson method in which the teacher talks to the class, asks questions and answers questions which the children may ask, performs experiments and uses visual aids, and then sets the class notes to write. But I think wherever possible we should give these senior children opportunities for dealing with problems and topics along lines which will encourage them to think for themselves and to discuss problems which arise in the work. Let me illustrate what I mean by reference to a few examples.

Lessons on breathing lead to the problem of smoke and smoke abatement

Practical problems—not theory

In one instance the topic being studied was "biology and the home". First we discussed why certain houses in our neighbourhood were considered good houses and others were not so good. Then by asking them questions, by experiments, by examining samples of materials used in house construction, we learned something about the problems of dampness, about lighting, heating, sanitation, good and bad sites, types of houses, and rooms. We learned something more from a visit to a nearby museum in an institute of hygiene dealing with house building and sanitation. Following this work I invited the Borough architect to come along to the school to talk to the children for half an hour. This he did and made very effective use of diagrams, protographs, illustrations and models. This left half an hour for the children to ask questions. These teenagers would in a few years time be considering a house of their own and they were so intensely interested in the subject that they gradually left their seats and gathered round the architect in their eagerness to learn, and the discussion went on for forty minutes after the school session had finished. The following week the same procedure was adopted with an expert on house furnishing.

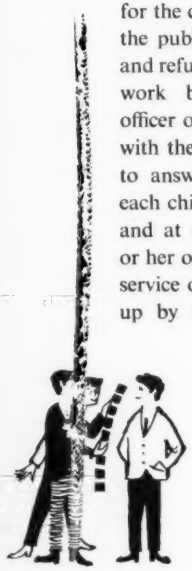
In this type of work the children did not make a single note in their books, neither were they set any questions to answer. The method was one of group discussion to set them thinking about real life problems. In addition, arrangements were made for a series of visits to a site on which houses designed by the Borough architect were being built.

Exploring new teaching methods

I have used this discussion method in dealing with the subject, "health and the

community ". After a preliminary lesson on the work of the Ministry of Health, the local health committee and the medical officer and his staff, I invited the chairman of the local health committee and the medical officer of health to speak to the senior class for about twenty minutes and then allowed twenty minutes for discussion and questions. This was followed by visits from the chief public health officer, the senior nurse, a matron of a hospital, a doctor, and the assistant Borough engineer who was responsible for the disposal of sewage and refuse and the cleaning of the streets, and in each case the same procedure was adopted. Each time the class displayed the same keen interest and it was obvious that these teenagers were anxious to learn what was being done to maintain the health of the community and to learn what they themselves can do.

Other methods of dealing with this work with the senior children have been equally as fruitful. Again in studying the topic " health and the community " on another occasion, I made arrangements for the children to visit the various clinics, the public health department, the sewage and refuse disposal works to see the actual work being done. Then the medical officer of health came to school to discuss with the children what they had seen and to answer their questions. In this case each child had to make notes of the visits and at the end each had to compile his or her own booklet describing the " health service of our town ". This was followed up by two lessons (using filmstrips) in which I gave an account of what is being done in other countries and of the work of the World Health Organization.



The children made a film-strip

On another occasion in dealing with " health and the community " I gave the class an introductory lesson on the health services provided in Great Britain and then told them they were to make a filmstrip themselves entitled " the health services of our town ". This was a real challenge to them for it meant they would have to visit the various health services to see what work they did, and meet the people engaged in the work, before they could take the necessary photographs and write the notes to accompany the filmstrip. It should be mentioned that the children concerned in this work had had some experience in making films through the activities of the school film society and had helped me in making other filmstrips for use in school. The class formed themselves into a production committee and shared the work out; some taking the photographs, some doing the developing and enlarging, some making the necessary title cards, and others writing the notes. My job was simply to act as adviser when called upon. The result was the children got a very good idea of what was being done to keep the town healthy, and also it gave us a filmstrip which has since been of great value in lessons on public health.

It is, of course, not always possible to do this kind of work with senior children. Sometimes one seems to get a group of children who would benefit more if the work is done by the usual class-room method of teaching. Or again, perhaps one has not been able to complete the preliminary course in the second and third

We must use methods which will encourage the children to think for themselves

years in biology in the allotted time and so there is not time to deal with the work on "biology in the service of man" by these more specialized methods which do require more time to carry out.

Close cooperation is needed

Obviously to carry out this type of biology teaching and health education it is essential that there should be close cooperation between the teacher carrying out the work and the local health authorities. Both will benefit from such co-operation and the result will be more healthy citizens with a greater understanding of the work being done by the health authorities to maintain a healthy community.

Did you know that...?

DID YOU KNOW THAT the study theme for the 1959 Summer School organized by the Central Council for Health Education in Great Britain will be "The Dynamic Approach to Health Education"? The School, to be held 18-28 August at the University College of Bangor, on the North Wales coast, will offer an intensive practical refresher in modern health teaching methods, tuition by experts in film and filmstrip making, guidance in group leading and public speaking, etc. The fee for the course which is residential is £22. Applications should be made to the Central Council for Health Education, Tavistock House North, Tavistock Square, London, W.C.1.

DID YOU KNOW THAT a course on the use of audio and visual aids in community development, including health and agricultural extension work, will be held at the Oversea Visual Aids Centre, 14-24 July 1959? The course will consist of talks and demonstrations by experts, and will include a considerable amount of practical work. The fee for the course which is non-residential, and limited to twenty, is £18. Those wishing to attend should apply to: The Oversea Visual Aids Centre, 31 Tavistock Square, London, W.C.1.

DID YOU KNOW THAT full-time health educators, officially designated as such for the first time last year, are now at work in the Province of Natal in South Africa? The provincial health services now have 30 health educators, whose basic training lasted three years and most of whom have had more than five years practical experience at the Institute of Family and Community Health in Durban.

DID YOU KNOW THAT the Standing Health Education Commission of the Czechoslovak Medical Society organized its *first* Seminar on 18 December 1958 in Prague? Lectures on the evaluation techniques and problems and the role of fine arts in health education were followed by lively discussions on the part of the 60 doctors and other health workers attending the Seminar.

DID YOU KNOW THAT Czechoslovakia has launched a National Health Education Review? The first issue to come off the press in 1959 was devoted to the health education of children and youth.

We built

A small Philippine village provides itself with a multi-purpose device to promote health, privacy, love of beauty, and a happier life for everyone.

From my bedroom window here in Bactad, I can see the public artesian well where the people have learned to congregate to wash clothes, to bathe not only themselves but animals as well, to scrub dirty pots. Where filth and confusion prevailed for years, there is now cleanliness, beauty, harmony and privacy.

How did this happen, and how much did it cost? The story is very simple. Two years or so ago, my wife and I and a group of friends visited some parts of rural France. There we found situations and problems very similar to our own. The people did not have electric light or water laid on. They lived in some degree of isolation just like our village folk in the Philippines. But they did have a community bath- and wash-house, which was nearly always in the centre of the village, near the rural church and community market. It was a concrete place in the shade, where the women did their washing by turn.

When we returned home in September last year, I was once again confronted by the unsightly artesian well in the village of Bactad. Early in the morning there was a horrible confusion as women fought to be near the source of the water to do their washing more easily. The well was used indiscriminately for bathing, washing clothes, scrubbing pots, pans and kitchen utensils. The most disgusting feature was the stagnant pool that had been accumulating for years as a result of clean and dirty water flowing into the field. Pigs, chickens, and other animals used to wallow in the mud, and, of course, mosquitoes bred there in the thousands.

What could we do to follow the example of the French villages? We gathered a few of our village people including some teachers, and described the community bath- and wash-house we had seen in rural France. They all liked the idea, and

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After serving as a specialist in education at the U.S. Office of Education in Washington D.C., and as principal of a pilot community school in one of the Indian schools of South Dakota, he returned to the Philippines. His next appointment after the war was Superintendent of Schools and Chief, Curriculum and Research Division of the Philippines Department of Education.

Pedro Orata has been with Unesco as Programme Specialist since 1948.

His hobby is still today working with people in villages.

ilt a community bath and washhouse

by Pedro T. Orata

when we proposed to build a similar one near the artesian well and the school, every one volunteered to help. So, we decided to build one; my wife and I gave the cement and the thatch roofing.

The mayor gave the sand and gravel. The people provided the needed bamboo and palm leaves, and did all the work. A high school shop teacher designed the building and supervised its construction while village officials organized the people in the different zones to contribute materials and labour.

It took less than two weeks to finish the construction; it took six bags of cement, one truck of sand and gravel, 350 sheets of thatch roofing, fifteen pieces of bamboo, five buri leaves, and one-half kilo of nails. All in all, counting labour, the bath- and wash-house cost about forty pesos, or twenty US dollars.

First, we separated the waste water from the clean water—the waste water being directed to a canal which carried it into the rice fields; the pure water, especially at night when the artesian well is not in use, goes into a large fishpond a few metres from the well. The fishpond is fenced around and on its raised sides are planted vegetables.

The filthy stagnant pool has dried up and where the pigs and poultry used to wallow, there is now a flower garden which is cultivated by girl students of home economics. The women no longer scrub their pots and pans there, for they too admire beautiful things and want to preserve them.

Then they no longer need to fight for the source of water because the wash-house has separate taps and gives room for three or four women to wash clothes at the same time. The wash-house is strictly private, and the women enjoy being left alone; they can wash at any time of the day, rain or shine. It is fitted up with utensils for scrubbing and pounding the clothes, rinsing and hanging them.

There is no more bathing in public. Men, women and children now use the private bathroom for the purpose, and line up to take their turn. The habit of bathing privately is being formed quickly now that a private bathhouse has

The schoolchildren took an active part in the project

been provided. Heretofore, many laws have been passed prohibiting bathing in public, but like many other measures, they could not be enforced because there was no alternative.

There is an educational value for the young and old as well in all this. Pupils in all grades shared in surveying the problems and needs, in making the plan and carrying it out, and later appraising the results. Questions such as these came up: Why do people bathe and wash clothes in the open? What is the danger to health of the foul water which has accumulated near the artesian well? What can be done with the good water, especially at night? Where should the waste water go? What can be done to help in building the bath- and wash-house?

The pupils took an active part in the construction of the building: they carried the sand and gravel in small containers; they separated the large stones; the home economics girls converted the ground around the well into a flower garden; the bigger boys helped to split bamboo or dig holes in the ground for the posts. After the building was completed, all the classes took time to see it and to be shown how the various parts were to be used—the taps in the wash-house, the towel rack in the bath-house, the brooms and water containers in both, etc. Then, came the problems of maintenance—who would be responsible for cleaning the floors and not allowing water to accumulate? Of course it was decided that those using the place should themselves thoroughly clean up afterwards. The pupils volunteered to take care of the canals so that they did not get clogged, taking turns to do so.

Before the women were allowed to use the facilities, they were gathered together by the school principal, who advised them that they should leave the place as clean and tidy as they found it, " as they would wish " to find it—and proceeded to show them how. They readily agreed that unless they took great care of the house themselves, it would not last long, and " what a shame that would be "... All this is part of the effort to educate the people to make intelligent use of their own resources and help themselves to better health.

" ...education does not consist in possessing not simply a multiplicity of ideas and facts, but also a flexibility and rapidity of mind, ability to pass from one idea to another, to grasp complex and general relations, and so on. "

George Hegel

Today, a child cannot be considered any longer on a isolated entity; it is part of a family and is influenced by this family according to the degree of evolution of the parents, to their knowledge in the field of health, education and psychology, according also to the kind of human relations which exist at home.

Congress of l'*Œuvre nationale de l'Enfance*, Brussels, 1958

Public opinion seems to accept bad teeth or even artificial teeth as a necessary evil and usually displays little interest towards dental health. Two main factors appear to be at the root of this indifference: fear of the dentist and ignorance of the importance both of oral hygiene and of certain aspects of nutrition. Tackling the problem with children, the Essex County Council in Great Britain recently launched a pioneer three-purpose health education campaign, preceded and followed by surveys to assess the value of the educational effort.

The Braintree experiment

by Frank St. D. Rowntree

Dental health seems often neglected in favour of other more dramatic aspects of public health. This is possibly because of the apparent limitations of the subject and the difficulties encountered in stimulating interest amongst the public.

Evidence which supports the need for greater dental health education activities was given in the report of the Ministry of Health (London, June 1955), in which it was stated that during the first five years of the National Health Service, 1948 to 1953, approximately £100,000,000 was spent on the provision of artificial teeth, and that if the demand over this five year period were maintained an estimate could be made that approximately 1 in 6 people in Great Britain would be wearing full upper and lower dentures within the space of a very few years, two-fifths of this group being under the age of 45 years. It was also pointed out that children aged five years have, on an average, five of their milk teeth decayed, missing or filled.

This situation is becoming progressively worse since the de-rationing of sugar in Great Britain in 1947. Much of the apparent indifference to the low state of dental health probably stems from the fact that dental disease is not a dramatic " killer " and in the minds of many people, the necessity for artificial dentures is inevitable by middle age.

The need for dental health education has been recognized by many members of the dental profession and over the past few years a limited amount of low intensity education has been carried out in various parts of England and Wales. This has been mainly in the form of occasional talks to expectant mothers and mothers of young children in clinics and welfare centres, and single lessons to children in schools.

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In Essex it was felt that this approach was hardly adequate, and during 1957 a number of pilot experiments were carried out, including exhibitions held during agricultural and horticultural shows, to associate the consumption of foods such as raw apples, carrots and celery with the prevention of dental caries. As part of the exhibitions, demonstrations were given by an oral hygienist on the effects of sticky carbohydrate foods on the teeth, and the cleansing effect of raw fresh fruits and vegetables.

For the dental health week: three aims

The results of these experiments showed that it was possible to stimulate an interest in the subject, and it was decided to undertake a full scale dental health project within a school community with a view to assessing the effectiveness of dental health education.

The school chosen for the project is situated in a country town of approximately 10,000 population. It has only recently been built, with every modern facility, including a large hall and classrooms in which there are individual toilet and washing facilities. There are places for approximately 450 children, and on the school rolls are children between the ages of 7 and 11 years, most of whom are drawn from upper working class families on modern housing estates.

Preliminary discussions with the headmistress of this school resulted in the offer of enthusiastic co-operation and it was decided that a dental health week should be held during which time the focus of all school activities would be dental health. It was agreed that this would take place during February 1958.

The objects of the dental health project were based on the three main problems:

(a) the removal of fear of dental inspections and treatment;

(b) the establishment of correct attitudes, i.e. the importance of finishing meals with detergent foods especially at times when it is inconvenient to use a tooth brush;

(*c*) the establishment of good oral hygiene habits.

The co-operation of the teaching staff was sought and a number of meetings were held with them during which an explanation of the aims and objects of the projects were given. The teachers agreed to give maximum support to the venture and for a period of approximately four weeks prior to the main project they were supplied with a variety of material which could be used during their general class work. This included teaching notes on dental health, leaflets, posters and small display units. Wherever possible references were made to dental health in the general teaching programme. These activities gained intensity until the school half term, during which time preparation was made for the health week.

In order to assess the effectiveness of the project surveys were carried out.

These were of two types and consisted of a clinical assessment of the oral hygiene state of the children and an educational survey—we considered as very important—of their knowledge and attitudes towards dental health. To this end a questionnaire was devised, consisting of ten questions. Copies were supplied to teachers five weeks before the health week and were answered by the children in class without notice, before any dental education proper had begun.

The clinical survey was carried out by the local school dental officer as part of the normal routine dental inspection. A system of classification was devised :

Class A—High state of cleanliness;

Class B—Minimum state of cleanliness, showing inadequate cleansing routine;

Class C—Very bad mouths showing absence of care or cleansing routine.

The dental chair becomes popular

The activities during the dental health week consisted of film shows, dental health activities in the classroom relating to the general school curriculum, meetings between dental, medical and teaching staffs and between parents, teachers and dental health educators and as the focal point, a large dental exhibit erected in the school.

This exhibition consisted of three cubicles approximately 10' x 6', each centred on one of the main objects of the campaign :

1. *Removal of fear*—A completely equipped dental surgery, including dental unit, operating light and all the equipment normally associated with dental treatment.

2. *Food*—Displays of foods which cleanse and foods which cause decay, stress being laid on sticky carbohydrates as caries causing, and raw apples, carrots and celery as detergent foods. Milk was included as a body building food and tooth brushes were displayed as part of the preventive foods section.

3. *Establishment of oral hygiene procedures*—Eight coloured three dimensional "tooth brush technique" displays were shown together with a large free standing unit which consisted of a series of illuminated push button question and answer panels.

As stated, the exhibition was erected during the half term vacation of the school children who were completely unaware that the project was to take place. The purpose of this was to observe the reactions of children to the presence of the paraphernalia of dentistry in the school and it was particularly interesting to note the apprehension on the faces of many of the children during the first half hour or so, in which time the project was explained. During the course of the exhibition the classes which numbered approximately 40 pupils each were divided into two groups of 20, one of these groups being conducted over the three sections of the main exhi-

The children were given an opportunity to manipulate the dental chair—and soon their fear vanished

bition by an oral hygienist who gave simple demonstrations of the structure of the teeth and the cause and effects of dental decay. Special brightly coloured wax teaching models were used for this demonstration. These same children were then conducted over the three cubicles. In the first unit a demonstration of the workings of the various pieces of dental equipment was given in order to familiarize the children with the contents of a dental surgery. They were then given an opportunity of manipulating the dental chair and other equipment. It was interesting to note that following this demonstration and practical activity all signs of apprehension disappeared. It was decided as a result of this to allow the children free play during break times and after school hours in this particular unit and it became an extremely popular part of the project.

In the second cubicle, effects of chewing sticky foods and sweets were demonstrated by means of small black liquorice sweets. These were chewed by the children who then had an opportunity of examining each other's mouths with dental mirrors to see the black particles adhering to the teeth. The children were then given small apples to chew and the striking cleansing effect of this detergent food was shown to great effect.

In the third cubicle correct oral hygiene procedures were shown and explanations given of the various types of tooth brush available and their methods of use. Following the conducted tour of the exhibition the children were allowed time to examine each exhibition unit including the illuminated question and answer board.

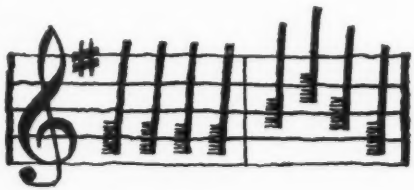
This is the way we clean our teeth
Clean our teeth, clean our teeth
This is the way we clean our teeth
To keep them strong and healthy

During the course of these demonstrations the other half of the class visited a film display including " No Toothache for Noddy ", " Let's Keep Our Teeth " and in certain cases " Gateway to Health ". Each class was taught a dental health song with actions, which became the theme song of the dental health week.

Dental health was also introduced into the various aspects of the normal teaching programme. This included reading, arithmetic, science, general project work, etc. The display of posters in the classrooms continued and also the distribution of leaflets many of which were included in dental health folders produced by the children. The contents of these leaflets were taken surprisingly seriously by the children and evoked numerous questions from them on specific points.

Teachers and parents show keen interest

It was felt a satisfactory conclusion to the project could not be reached without meetings for parents and teachers and consequently two evening meetings were arranged. The first was with members of the teaching staff of this particular school and other schools within the area, members of the dental and medical professions, school nurses, health visitors and health educators. During the course of the meeting the aim and objects of dental health education were given with special explanation of the project being carried out in this particular school. The



teachers were shown the series of films and then invited to ask questions and discuss dental health problems. Following the meeting, participants were conducted over the exhibition and received a supply of visual media together with a source list of other materials and films. Teachers from other schools were given the opportunity to have dental health films and exhibition material supplied to them. This offer started a chain reaction of dental health education which spread through other schools in the area, with requests for further dental health weeks.

A similar meeting between parents, school staffs and medical and dental officers was arranged. A surprising amount of interest was shown by the parents and the range of dental health topics discussed was extremely wide.

At the end of the week's project it was agreed that low intensity activity should be continued by class teachers. References were made when possible to teeth and their care during the course of the general school curriculum. Attempts were also made to change the practice of eating biscuits during school breaks and encouragement was given to the practice of consuming apples or carrots, particularly at the end of the mid—day meal. This low intensity education will continue indefinitely and will be supplemented at intervals by dental health weeks.

At the end of a period of six months further clinical and educational surveys were carried out, with the same questionnaire, the same system of classification and the same dental officer.

Their opinion on the dentist and sweets

Extremely interesting information was provided by the children on their attitudes to the dentist. Less than half considered that his function was to protect their teeth and about one-third considered him as "a puller-out" of teeth only. The preoccupation with extractions was high with the lower age group: this may be a reflected attitude from the parents. Almost three-quarters of the children thought that twice yearly dental inspections were adequate. It was again with the younger children of the seven and eight age range that misconceptions occurred. For instance eight of the seven year old boys thought that a weekly inspection was necessary. The children had definite ideas about eating after teeth cleaning, particularly at night, and 75% of the children thought this was a bad practice. It is interesting to compare this with their statement on the practice of teeth cleaning at night.

Generally speaking, the knowledge of the children was quite high though there was considerable room for improvement, particularly on the question of the function of the dentist and the times of eating sweets. The overall knowledge increased with age but a comparison of the knowledge state with the first clinical survey, indicated that as their knowledge rose, their oral hygiene standards fell.

Six months after the first survey and approximately five months after the dental health week, a second survey was made.

The attitudes to food had altered considerably—almost all the children now realized that raw apples, fresh fruit and vegetables are better for teeth. The most striking change however was in the attitudes to the dentist. There was a doubling in the number of children who believed that the dentist's function was to protect teeth and a considerable fall in the number who believed that his function was to pull out their teeth (27% to 10%).

	Written Surveys	Before	After	Improvement
		%	%	%
1.	Children possessing toothbrush	96	99	3
2.	Children sharing toothbrush with family	9	3	6
3. *(a)	Possessed toothbrush for a month or more . .	38	39	
(b)	Possessed toothbrush a year or more	36	42	
4.	Children who use their toothbrush	94	95	1
5.	Consider teeth brushing last thing at night most important	9	15	6
6. (a)	Consider apples best for teeth	87	99	12
(b)	Consider sweets best for teeth	2	0	2
7. (a)	Eat sweets immediately after meals	43	55	12
(b)	Eat sweets between meals	31	23	8
8.	Consider dentist protects teeth	41	78	37
9.	Consider twice yearly visits to dentist the proper intervals	73	84	11
10.	Eat after cleaning teeth	21	8	13

The process of deterioration is reversed

The clinical survey carried out before the dental health week provided extremely interesting data on the oral hygiene of the group. The D.M.F. rate was not used as the index of success but comparisons were made between the standards of oral hygiene of the children before and after the campaign, to assess the results of the educational effort.

The following table gives a distribution of Class 'A' and ' B ' mouths by age and sex. There were no examples of Class ' C ' mouths. Generally speaking, the mouths of the girls were better than the boys although they were less so as the age increased. The oral hygiene of all the children deteriorated as the age and knowledge increased.

Clinical Survey I		7 yrs.	8 yrs.	9 yrs.	10 yrs.	11 yrs.	Total	Grand total
		%	%	%	%	%	%	%
Class 'A' Mouths	Boys	59	75	60	43	41	58	62
	Girls	79	77	63	65	37	66	
Class 'B' Mouths	Boys	41	25	40	57	59	42	38
	Girls	21	23	37	35	63	34	

The same group of children were examined six months after the first survey and an overall improvement of 13% was registered. An examination of the age groups shows that the percentage of Class 'A' mouths now increases with age and is reverse to the position in Survey I. The number of Class 'A' mouths is still higher amongst the girls than the boys. The trend is for an increase in the standard of oral hygiene but the main effect has been on the older groups of children. The tendency of the mouths to decrease in standard with age has stopped and now as the knowledge increases so does the oral hygiene.

Clinical Survey II		7 yrs.	8 yrs.	9 yrs.	10 yrs.	11 yrs.	Total	Grand total
		%	%	%	%	%	%	%
Class 'A'	Boys	60	74	58	77	68	68	75
Mouths	Girls	67	78	83	80	87	82	
Class 'B'	Boys	40	26	42	23	32	32	25
Mouths	Girls	33	22	17	20	13	18	

The project provided interesting and valuable information on the knowledge, habits and oral hygiene of young children, and the effect of an intensive propaganda campaign to improve them. The experiment also gave an indication of the types of approach most suitable for work with children and the need for the development of further special techniques, particularly for boys.

The results of the surveys suggest that educational campaigns can result in improved oral hygiene and a greater awareness of the benefits to be derived from dental health, particularly where the cooperation of parents and teachers is gained.

I gratefully acknowledge the guidance encouragement and help given to me by Mr. John Byrom, Chief Dental Officer Essex County Council, both in the execution of the project and in the preparation of this paper. My thanks are also due to Dr. George G. Stewart, Essex County Medical Officer, for his permission to publish these findings.

Micronesians train for health education

From 27 October to 21 November 1958 thirty seven Micronesian medical practitioners, sanitarians, nurses, teachers, community development workers and other health workers from the Territory of Guam, Saipan, and the Trust Territory of the Pacific Islands met together on Guam for a four week health education training course. The course was sponsored jointly by the Government of Guam, the United States Navy-Saipan District and the Trust Territory of the Pacific Islands, with financial assistance of the Guam Tuberculosis and Health Association.

The staff was made up of qualified public health and educational personnel from the area and of consultants from WHO and the International Cooperation Administration.

The mornings were devoted for the most part to small group discussions on study topics which had been developed by a joint staff-trainee planning council from material submitted prior to the course period. Afternoons were spent in " special interest groups " which were developed in the areas of sanitation, communicable disease and school health. Plenary sessions were presented from time to time by the study groups and staff using various method of presentation such as panel discussions, role-playing, flannelgraph, and buzz group.

Evaluation and follow-up are planned for the course and a member of the staff expects to visit each trainee in his home area after a six-month period.

Could *you* have done this?...

Some time ago, in these columns, *Janus* reported a case in which a pious Hindu gentleman had taken delivery of a water-seal latrine but had then been overcome by doubts as to whether its use was not at variance with the tenets of his religion.

From the health education point of view *Janus* was interested to know by what arguments the man had been led to withdraw his objections. The answer has now been supplied by the health educator in South India who did the persuading.

I went to meet the old man (he writes) and, after introducing myself and inquiring in a friendly way abou his domestic affairs, I tactfully introduced to him the reason for my visit, explaining to him the advantages of our new type of latrine; how it would help to preserve and promote the health of the community if it became popular and asked him for his opinion of it.

What Lord Krishna said

He heard me patiently, then said that whatever its advantages he personally would not be prevailed upon to use it since by doing so he would have to defecate into and pollute the water in the seal which he believed to be a sin and a contravention of a line from the Hindu purana Bhagavat Gita comprising the teachings of Lord Krishna, the incarnation of God, to Arjuna.

In this holy poem the Lord says, " I am the life of all elements including water ". The old man added that, since he was a firm believer in the teachings of the Lord, he would not countenance the desecration involved by using the water seal latrine and that, had he known of its function previously, he would not have purchased the slab.

A change of the front

Then I started my arguments by saying that I was also an orthodox Hindu like himself and agreed with him that what Lord Krishna said about water was true, as it is the life-sustaining element of all living things.

Polluting water to be used for drinking and other specific purposes was undoubtedly a sin, as he had stated, but on the other hand we had to make a distinction between water used for these purposes and for say, ablution. By ablution, which we must of necessity practise for the sake of hygiene and cleanliness, especially after defecation, the water is then also unavoidably polluted. If we did not make such a distinction then he himself, and all other Hindus, were constantly committing the very sin which he now condemned.

A further argument was that by using open ground for defecation, the rainwater which fell on the spot would be contaminated by his action and thus he would be guilty of a sin according to his own reasoning !

The final argument

I went on to remind him that we Hindus believe that one who takes a bath in the sacred water of the holy river Ganges is cleansed of all his sins, yet that water is being polluted by the very pilgrims who visit the famous temple in Benaras, by their indiscriminate defecation on the banks and even in the river itself.

How is this reconcilable? Lord Krishna declares his purifying spirit to be in water, and so it is; for the laws of nature, which are divine, ultimately purify the water contaminated by our actions. I concluded that so long as God, by his divine power through nature's laws, eventually maintained the quality and life in water, no sin could be committed as long as it was used for the purpose of hygiene.

At this he agreed with my contentions and promised to make use of his latrine. I thanked him for this wise decision and when I visited him during the following week he confessed to being happy to continue using such a good type of latrine.

What's the moral?

The moral? Just this: what would have happened had the health educator been a European with no knowledge of the man's religion?

Janus happens to believe that those who presume to educate others should first educate themselves in the beliefs, customs (yes, and language, too) of those whose attitudes they wish to change.

He also thinks that, in countries where religion is a living force in the life of the vast majority of their people, health workers would not be ill advised to make it a priority in their studies.

But who, anyway, is...

... JANUS?

A N C H E P news

The first annual meeting of the American National Council for Health Education of the Public brought to near-completion preparations for participation by the United States in the 4th International Conference on Health Education.

Coincident with the meeting there was published two documents reflecting the views of more than 45 US health organizations on matters to be discussed at the IUEP and WHO sessions. A special committee is drafting a supplementary report on behalf of ANCHEP.

At the banquet session—held jointly with the National Conference for Cooperation in Health Education—an inspiring address was delivered by Dr. Carlos L. Gonzalez, Assistant Director, PASB/WHO, on " Health Education Horizons in Latin America ". Dr. Donald A. Dukelow spoke on the work of the Joint Committee on Health Problems in Education, of the American Medical Association and the National Education Association.

Elected as new President of ANCHEP was Dr. Henry van Zile Hyde, formerly a Vice President. Dr. Hyde succeeds Mr. Basil O'Connor, who was elected Vice President. Dr. Hyde is US member of the WHO Executive Board. Other Officers were re-elected.

An outstanding feature of the three-day meeting was an evening session at which Americans who have served on overseas health education assignments assessed their experiences. Discussion leader was Dr. Beryl J. Roberts of the University of California and President of the Society of Public Health Educators.

Training in health education —a challenge

1959 international health education events were inaugurated by the coming off the press, in January, of a WHO Expert Committee Report dealing with the training of health personnel in health education of the public. This 40-page booklet, which marks another milestone in the progress of health education, contains the views of a group of experts from Chile, England, Sudan, the United States and USSR, who met in Geneva, 28 October- 1 November 1957, to discuss the problems raised by " the need to prepare professional health workers for their health education work with individuals, families and the general public ".

This is an excellent report and must be read.

" The attainment of a state of well-being rests upon personal resolve. Resolve depends upon attitude, attitude upon insight and insight upon knowledge, experience and feeling. The methods of health education have developed with the specific aim of helping people to make choices about health more wisely. " This quotation may serve to illustrate why health education is the most challenging and also the most difficult concept of public health. In a sense public health *is* the health education of the public. For this reason there is danger of losing precision of view of health education as a method and approach in a wider and vaguer statement of the aims of public health itself. When health is described in the lofty terms of the World Health Organization definition the stated role of the educator in this mystique may be made to exceed that of Plato's philosopher kings.

Quis docebit ipsos doctores ?

by John Brotherston

Not an apostolate—nor a bag of tricks

There is a dilemma. If the claims for health education are made too wide, we are led into a wilderness of well-doing, where the health educator looms vaguely as an apostle in a mirage of the Good Life. Yet if health education is conceived too narrowly, it may appear as a bag of tricks for persuading the public, and the health educator becomes suspect as a mere exponent of gimmickry, without knowledge or values to give sound direction to his work.

Dr. Zaki, Chairman of the Expert Committee, and his colleagues have produced a statement full of interest and good sense. Inevitably the field of work for health education which they sketch is almost frighteningly wide. But they

make sound and practical proposals for training in health education not only specialists but health personnel generally, doctors, nurses, sanitarians, etc., and also other key professions such as school teachers. They emphasize that training in health education goes far beyond instruction in visual aids, it must be founded on an understanding of sociological and psychological principles as well as local knowledge.

The report is also realistic in its respect for the established practices of different communities, in its recognition that health beliefs and practices may be deeply rooted in socio-cultural systems, and in its counsels against perfectionism.

Health education should be provided for parents to help them with their vital task of raising the next generation, for children and adolescents to inculcate an approach to healthy living, for leaders in industry, politics, press and radio because of their influence upon health policies and public attitudes. Almost every contact between doctor or nurse and patient has educational significance if rightly managed. Hospitals and other medical institutions should educate to prevent recurrence or relapse as well as giving physical treatment. In our plans and policies we must look beyond the boundaries of the health services to a partnership with all the services—social security, education, agriculture, industry, etc.—which are concerned with public well-being.

Learning to choose

The report summarizes so much in its few pages that any discussion must be regarded not as criticism but as comment. Like politics health education is the art of the possible. The potential field is vast, yet the immediate possibilities are limited ; in health education training there is need for emphasis on priorities and the criteria of their choice. The report states " there should be greater recognition of the urgent needs and opportunities for education in mental health as it affects the home, schools, colleges, industry, and the community at large. This should apply particularly to the quality of emotional life which parents provide for their families, the emotional climate of the class-room and the college, the realtionships within industry, and the degrees of participation by the people in affairs of Local Government. " One is tempted to ask—why stop there ? What about national and international affairs ? After all the hydrogen bomb is quite a health hazard in its

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" I've never been in prison, I've never crossed the Gobi Desert and I've never written a best-seller " protested Prof. Brotherston when asked for a biography... Indeed the life of the Dean of the University of Edinburgh has been so fully occupied with studies and teaching that little time was left for anything else ! John Brotherston first studied arts and medecine at the University of Edinburgh. Then, after serving as Regimental Medical Officer in the Middle East and Germany during World War II he received a Rockefeller Fellowship and went to the London School of Hygiene and Tropical Medicine where he took his D.P.H.

After a year as Lecturer in Preventive and social medicine at Guy's Hospital Medical School in London, he travelled to the United States—also on a Rockefeller Fellowship—to obtain his D.P.H. at Johns Hopkins and take part in a public health service survey of graduate schools of public health.

After four years as Senior Lecturer, then as Reader in Public Health at the London School of Hygiene and Tropical Medicine, he returned in 1955 to his home town University where he has since been teaching public health and social medicine. He is keenly interested in community use of health services and in medical education.

Hobbies rate as golf and, as he says rather wistfully, " any other agreeable way of wasting time ".

own way. The real difficulty is not to find good deeds to do, but to know where, when and with what to begin. Critical choice of the attainable is an essential exercise in training for health education, if we are to avoid the opposite dangers of premature enthusiasm and cynical inactivity.

Doctors and nurses: insight must come first

The report reminds us that education should be a large part of every health worker's task, and that they should be trained to meet this responsibility. It would be impossible to over-emphasize the importance of this statement, but there are difficulties to face. The modern hospital is a technological enclave where the patient is regarded as the passive beneficiary of scientific medicine ; this is the atmosphere in which the doctor and the nurse are raised. The education of both doctor and nurse tends to inculcate an authoritarian attitude, valuable sometimes in dealing with acute illness, but a serious handicap in educating the convalescent or healthy patient. Existing patterns of hospital and home practice are sickness oriented. Education of the patient and his relatives is neglected because the need for it is not recognized, and in any case it is time-consuming and therefore appears to interfere with the jobs on hand. Training of the doctor and nurse for health education must first break down preformed attitudes before it can begin to be effective. But a start can be made by giving a clearer and more personal insight into the dynamics of the doctor or nurse patient relationship, and by demonstrating the important contribution which the patient and his relatives can make to their own well-being and the part which education can play in this.

The public health worker: understanding and sensitivity

The public health worker, self-selected from the medical or para-medical professions, is at present a deviant ; his case is different and altogether easier. It would be difficult to better this statement in the report : " the training (post-graduate level) of the public health worker desirous of helping people to improve their health practices must ensure that he has a thorough knowledge of the problems involved. He must have interest in and understanding of people and communities, including their attitudes, beliefs, current practices, and value systems. He must be aware of the possible effects of change on their way of life. He must know where to find information on resources that can be used to help with educational activities, and the ways of using these resources. He must understand the principles of health education and have command of the methods and media appropriate to his field work. He must know which educational methods are most likely to encourage desirable changes under different circumstances. "

The specialist: no ground for polemics

The most controversial subject o all is the role and training of the health education specialist. Too often the reasoned case for health education goes by default, obscured by the bitter polemics of an argument for and against the professional health educator. Perhaps some of the health educators have contributed to this atmosphere of religious strife by the evangelical zeal with which they have stated their case, but they have been mightily provoked by the dour resistance of conservative medicine.

The report describes with admirable balance and good sense the case for the

specialist health educator and outlines appropriate methods of selection and training. The real problem in training usually comes from the variety of backgrounds from which this profession is entered ; those who have little previous knowledge of public health have to achieve virtually a double training in a comparatively short space of time. Unless the health educator has a good deal of previous experience of scientifically based public health work, he or she must be comparatively unsophisticated in the choice of priorities for action. But if mistakes result from this in the field, it is the fault of the leader of the public health team, not of the health educator. As important as the training of the specialist health educator is the training of the health officer in the right methods of supporting the health educator and deploying his skill in the public health team.

Needed: a statement of applied social science

If a knowledge of biological sciences is important for the specialist health educator, some understanding of the behavioural sciences is important for all concerned with health services : " Successful education of the public in health matters not only rests on an understanding of the basic concepts in human behaviour, but also on a knowledge of beliefs and attitudes people have toward certain fundamental problems. Beliefs about disease and injury, and the treatment of these conditions, are woven into the matrix of social structure. People differ widely, though, in their understanding about illness and the ways they have developed for handling it, and they cling to their beliefs and attitudes with a tenacity that is often surprising. There is pertinent material in the social sciences which can be useful in helping to solve this problem, and there should be opportunity in the public health curriculum for its systematic presentation. "

This view that the behavioural sciences are basic to an understanding of public health work is comparatively recent, but is now fairly widely accepted. That it is so is in no small measure due to some of the first health education specialists who came into public health work from the field of educational psychology. Their message is thankfully received, but we have reached a point where a smattering of assorted ideas from anthropology, sociology and social psychology is no longer sufficient to satisfy our curiosity. The need now is for a statement of applied social science carefully related to the needs of public health, and so formulated that not only its scientific validity but also its relevance to his needs are apparent to the health worker whose basic training has been in the physical and biological sciences.

There is another general difficulty which is not faced in the report. How is all this largely new material from the behavioural sciences to be incorporated into the already overcrowded curricula of medical, nursing and public health nursing students? It is said (and quite rightly) that it is not just a matter of adding a few extra demonstrations on visual aids; but what is to be sacrificed in favour of this large volume of new material? This is a subject which requires to be discussed in the wider context of the replanning of medical and nursing education.

Training must instil a scientific approach

To what end and to what purpose do we educate? The 64 dollar questions are always so easy to ask and so difficult to answer. If the health educator is not

always able to validate his claims he is no different from educators in other fields. Nevertheless, it is important that training should instil deeply a scientific approach to the choice of objective and the evaluation of results. Without this at best much waste of effort and money may result, and at worst considerable harm. In primitive communities the number of problems amenable to improvement by simple measures achieveable by education is very great. In highly developed communities today many of the major public health problems are of complicated origin, imperfectly understood; as such they are often not yet amenable to clearcut policies of health education. The public health leader chafing for new worlds to conquer may be tempted to launch out into action. After all there is great fun in the stir and ballyhoo of large-scale propaganda campaigns, masquerading under the banner of health education. But if the objective is ill-chosen the results may be immediately harmful, and disadvantageous to better planned campaigns of education in the future. If no scientific attempt is made to evaluate results the sheer volume of noise may be interpreted as sufficient success. As the report says in its final sentence: " health education can influence the lives of people for many generations. The ethical responsibility of all who practise is therefore profound and can best be assured by careful selection and training. "

Spotlight on cancer in Costa Rica

The film—on cancer—was to have been shown in the girls' secondary schools of Costa Rica. But at the last minute the Ministry of Public Health had to alter its plans and arrange sessions in cinemas near the schools: the number of students interested had proved greater than expected and the school rooms were too small.

This incident was typical of the success of the Ministry's " Cancer Week ", held at the end of last October. The week had been carefully planned to cover cancer education individually as well as group-wise and to combine radio and press information with exhibits, film shows, the distribution of leaflets, etc.

While social workers from the cancer clinic " Marcial Fallas Diaz " and other consultation centres visited patients' homes, the group approach was realized through lectures, talks and demonstrations in the clinic. The showing to secondary school girls of the film " Cancer in Women " proved particularly successful.

The week itself was inaugurated by broadcasts from the Minister of Public Health and the Head of the Cancer Department. A popular radio play was broadcast on the same theme—also highlighted by the press through articles contributed by specialized doctors, editorials and photographs.

During the week, among other publicity material, 15,000 leaflets encouraging early diagnosis were distributed. Four hundred posters on the theme: " The Three Allies of Cancer: Ignorance... Delay and Fear " were displayed in shop windows of the city's main thoroughfares.

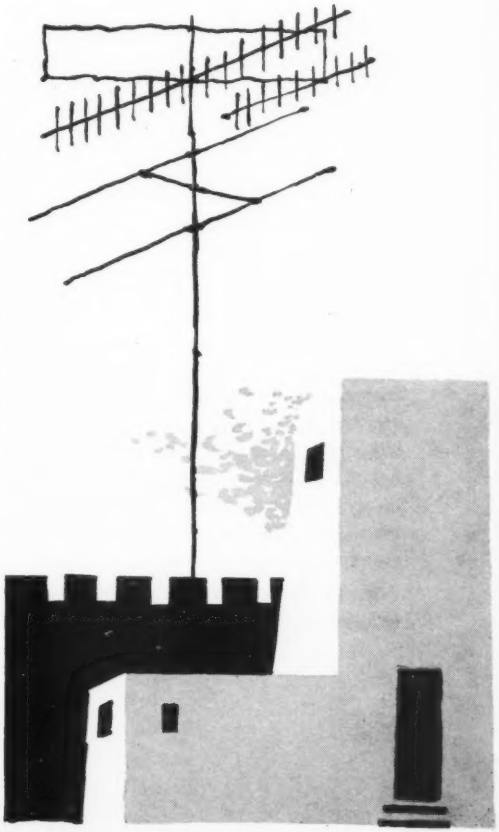
TV in Saudi Arabia

One year ago health education by television in Saudi Arabia was a "rose colored" dream. Today a full-fledged reality, it has a leading place in health education in the Eastern Province of Saudi Arabia. In this area where the spoken word reaches a much larger group than the written word, television with its visual-plus factor, is helping people to help themselves in matters pertaining to health.

by Mitchell V. Owens

Health Educator
Arabian American Oil Company
Preventive Medecine Division

Television came to Saudi Arabia in the latter part of 1955 when the American Training Mission began operating a 150-watt television station at the Dhahran Air Field. Shortly thereafter, television antennas could be spotted on the roofs of a few village homes. Then in September 1957, Aramco (Arabian American Oil Company) began operating its own 6000-watt television station for its Arabic speaking employees. The coming of Arabic television created a boom in the Saudi Arab television market and the rush was on to buy sets. Television dealers in the Eastern Province claim to have sold 471 sets and have orders for many more. In "cinemaless" Saudi Arabia, pictures that move are the ultimate in entertainment at present and will probably continue to be until day when motion pictures become a part of the Saudi's everyday life.



Though health films are used quite extensively in the Eastern Province schools, they are still limited to particular groups, and showing films to the general public is not practised.

The task of putting on a TV health show was given to the Health Education Section which is part of Aramco's Preventive Medicine Division. The Division's primary concern is the health of the Aramco employees and their dependents, but upon the request of the Saudi Government, it cooperates in various other public health activities. A prime example of this type of programme was Aramco's participation in a malaria control programme in the Qatif Oasis, that resulted in the reduction of the malarial parasite rate from a high of 85% in 1947 to a low of 6% in 1957.

The programme starts

When Aramco's Television Station opened, a new road for disseminating health information was established, not only to employees and dependents, but also to the homes which have had the least chance to see or hear this type of information before. A health series was planned and during the first week of programming, a show called *Your Health* was telecast for the first time. *Your Health* has been presented weekly since that time.

After the first few programmes it became evident that producing a weekly television show was no small undertaking and would require the service of a script writer with a general knowledge of Saudi habits, traditions, and customs. Fortunately, a person was obtained and has been generally responsible for the programme's success.

In the preliminary planning, it was necessary to determine the types of health programmes most acceptable and beneficial to the Saudi and yet within realm of attainment. Therefore, a tentative programme outline was established for each of the four monthly shows as follows: (1) Doctor Interview; (2) Local Health Conditions; (3) Health Film in Arabic; (4) Health or Medical Film with locally added introduction and Arabic commentary.

Health films in Arabic require a minimum of effort. Many however need an introduction or closing in order to adapt them to the local situation. Otherwise, very few are capable of producing the desired effect.

Health or medical films, produced in foreign countries with locally added Arabic commentary, facilitate the production of a health show. Their local effectiveness depends on the care used in screening the film for local adaptability. Approximately one film of this type is used monthly, always with an introduction.

The " *Doctor Interview* " programme is relatively easy to produce, although much depends on the doctor's " television personality ". Some interviews are live programmes, but most of them are filmed several weeks in advance. When the programme is filmed, it can be re-shown at various intervals and establish a television health film library.

The most difficult type of programme is that involving the filming of *Local Health Conditions*. This entails a detailed shooting script, transportation for the camera crew to the various locations, plus obtaining a satisfactory group of actors. These shows must be planned far in advance in order to obtain the best results. Finding the required props and locations plus familiarizing the actors with the script are additional problems.

Each month the Health Education Section prepares and distributes a health

" package " to all Company schools and 36 Government schools in the Eastern Province. This " package " includes a teaching outline, pamphlets, and posters to assist in teaching the health topic selected. The same health topic covered in the package is used in one or more of the television shows during the month. Thus, the increased emphasis on television programming gives the health package more impact and interest.

Most of the health shows are pointed toward a 15 minute programme although a few have been longer and some shorter. *Your Health* has been particularly fortunate in having good moderators and actors. On of the two most frequently used moderators is a Saudi Arab with specialized training in health education. His enthusiasm for his subject and sincere interest in the health of the Saudi population has undoubtedly been instrumental in the success of the programme. This particular moderator conducts his programmes primarily in colloquial Arabic. To add variety and prestige to the programme, another Saudi, a regular moderator with the television station, is used quite often. He has used predominately classical Arabic on all of the health shows in which he has appeared.

According to some of the more popular references on the subject, it is said that television is a wedding of radio, the theatre, motion pictures, the graphic arts, fine arts and electronic engineering [1]. It resembles each of its parents in certain respects, yet it has a personality all of its own. Here is how it differs.

(*a*) First, it gives a person a feeling of being spoken to directly. It is an intensely personal situation second only to a face to face situation.

(b) Secondly, the " here-and-now " feeling in which there is a sense of " being in " on something actually happening.

(*c*) It provides an opportunity for a two-way experience, that is, action and reaction or showmanship and audienceship.

(*d*) Finally, and perhaps most important, television's demand for attention. Whereas in radio you can do other things and still listen, television requires the individual's undivided attention in order to know what is happening [2].

Time for evaluation

With all of these things in mind and nine months of experience in production, it was felt that the time had come to see if *Your Health* was being watched by : (1) the Aramco employees and (2) the general public. Also, to find out how the people liked the programme and to obtain any possible suggestions for the programme's improvement.

Since the Company provides television sets for Arabic speaking employees in libraries and recreational centres, it was easy enough to " count heads " on the nights when *Your Health* was telecast and compare the number of viewers with those watching other programmes on other programmes on other nights. Another method of determining employee reaction to the health show was to interview Saudi employees known to have television sets. The more difficult job lay in interviewing the householders in towns where television sets were found in the greatest numbers.

Several questionnaires were prepared before one was finally chosen. It was then pre-tested and further changes were made to make it more reliable and understandable.

The value of any survey lies in the type of questions asked and the manner in which the inquiry is made. The interviewers were composed of two health education trainees, two male public health

nurses, one senior high school student, a female graduate social worker, plus a recent college graduate temporarily assigned to the Health Education Section. Each interviewer was thoroughly schooled on the necessity of being objective. Only 7 or 3.5% of those interviewed were women. This small group was interviewed by the female social worker. In general, there was no noticeable difference between men and women reaction in this small sample.

Is the health show watched and liked?

The primary objetive of the survey was to obtain the answer to two questions :

(1) Are the people watching the health show?

(2) Do the people like the health programmes?

It might appear that if question number one was answered affirmatively then question number two would also be affirmative, but in pre-testing it was realized that both questions would be necessary since it appeared that the great majority of people were watching all programmes, including the health show, whether they liked them or not. These two questions were answered quite dramatically as 94.6% of the householders indicated they were watching *Your Health*. It was interesting to note that 64.4% watched the show weekly, whereas 29.7% watched the programme occasionally and 5.9% never watched it.

There was also an apparent liking for the show as indicated by 99% answering " yes " to the question " Do you like the health programme? " This answer was pleasing of course, yet it is felt that regardless of how objective the interviewer might have been, the interviewee, after getting the idea that the survey was being conducted for information on the health show, automatically gave answers that he, the interviewee, thought the interviewer wanted to hear. The habit or custom of nodding the head in agreement with what is being said is a Middle Eastern characteristic that must always be considered when conducting a survey, teaching, or giving simple directions such as work assignments. This is especially true in those instances when the person giving the directions, or in this case asking the questions, is believed to be a person with a high degree of intelligence or authority. Therefore, if the questions had been answered by mail, comments would probably have been less favorable.

Question number one ... " Since when do you have a TV set? "... shows that the boom in television is continuing.

Length of Time Television Sets Owned by 200 Interviewees

No. of Months	*No. of Sets*	%
Under 1 month . .	4	2.0
1 to 3 months . . .	44	22.0
3 to 6 months . . .	65	32.5
6 to 12 months . .	45	22.5
12 months and over	42	21.0
Total	200	100.0

Taking into consideration the varying factors, such as number of television sets, family members, television-watching guests, etc., it is estimated that *Your Health* has an average viewing audience of approximately 4,050 persons outside Company facilities. Over a four week period, the average number of Company employees and guests watching *Your Health* in Company facilities numbered 744. This gives the health show an average of 4,794 viewers each week. It was interesting to note that 157 of those interviewed had an average of 4 guests per night to watch television.

First interest: other people

In comparing the health show with three other well known television programmes, the following question was asked: "Which one of these programmes do you like best?"

Programme Choice of 161 Persons Interviewed

Programme	*No. Persons*	*%*
World of Sports	17	10.6
Cowboy Pictures	34	21.1
Your Health	50	31.0
Travel Around the World	60	37.3
Total	161	100.0

Before the survey most of the interviewers believed *Cowboy Pictures* would be the most popular programme, yet only 21.1% chose this programme. It was also surprising that there was so little interest in sports, but this might be attributed to the fact that many of the activities shown on the sports show are games not particularly popular in Saudi Arabia. If soccer were shown each evening, undoubtedly *World of Sports* would be the most popular programme. The Arabs have been wanderers and travellers for years, so perhaps their interest in *Travel Around the World* comes from this background. Probably more reliable is the fact that *Travel Around the World* is an easy programme to understand, educational and highly interesting. One of the reasons *Your Health* is believed to be popular is its use of local people, familiar scenes and situations, plus the simplicity of the script. It is also hoped the people are stimulated by their desire to learn more about health. Since this question on programme choice was only the second question asked, with no previous reference to health by the interviewer, it should be relatively reliable. It was also interesting to note that 74% of the 50 persons choosing *Your Health* were Company employees. Are the Company employees and their families more interested in health? Possibly the continued emphasis on health within Company facilities has increased their interest in the subject.

When types of health shows were arranged in order of preference the ratings were as follows:

1. Arabic speaking doctors (Talks and interviews) . . 37.8%
2. Health films produced in other countries 32.1%
3. Showing local health conditions 21.1%
4. Interviewing local Saudis about health matters . . . 9.0%

It is pleasing to know that the viewers prefer physicians on the programmes since this is one of the easier programmes to produce and yet probably the most effective. It was disappointing to see that "Health films produced in other countries" were next in popularity, but again this may be explained by the remark of one Saudi when he said, "I like to see how the people live in other countries".

Originally, question number 8 on the interview form read, "For best understanding by you and your family, do you prefer colloquial or classical Arabic?" In pre-testing, 100% of those questioned said that they preferred classical Arabic. It was apparent that this was a prestige question; so the question was changed to: "For the best understanding by the people in your community, do you prefer colloquial or classical Arabic?" Even after changing the question only 21.7% said that they preferred colloquial Arabic. Yet, one of the more frequent complaints was that the Arabic used was often very hard to comprehend. One point definitely in favour of the classical Arabic is the fact

that there are many local dialects. In regard to the previously mentioned question in which the people were asked their preference for moderators, 48.5% liked the moderator using predominately colloquial Arabic and 51.5% preferred the moderator using predominately classical Arabic. This tells us little except to possibly refute the question in which the viewers preferred classical Arabic almost 4 to 1.

Women are the most resolute watchers

The two questions with possibly the greatest and most accurate information are questions 11 and 12 which read :

11. Did you see the health show on Baby Feeding last week ?

12. Did the women in your family see it ?

One hundred and twelve (55.4%) of the men interviewed said that they had seen the show. One hundred and sixty seven (82.7%), of 202 persons interviewed, said that the women in their families had seen it. Contrary to popular belief, that many of the Saudi women would have less opportunity to view television than her more sophisticated husband, it appears the women in Saudi Arabia, as in many other parts of the world, are the most resolute radio " listeners " and television " watchers ". Question number 11 is probably a better index of how many of the interviewees watch the programme every week, as previously asked in question number 3. In this question 64.4% reportedly saw *Your Health* weekly as compared with 55.4% seeing the " Baby Feeding " programme mentioned above in question 11.

The impact on health improvement

It is hard to visualize the average Saudi Arab who has a television set ; but summing up the information obtained from the questionnaire, he might fit this description : *He has had a television set a little over 6½ months, and he prefers to see programmes about travel. He likes to hear classical Arabic*, and *he watches over 50% of the " Your Health " programmes.* Interviewing Arabic speaking physicians is his favorite type of health show, and his wife watches *Your Health* more often than he does. He usually has many guests who watch the television shows with his 7 family members. He evidently likes both of the moderators equally well on *Your Health* and would like to continue seeing the programme weekly. He believes that additional programmes on baby care, family nutrition and housekeeping would be beneficial to his family. The average Saudi television owner does not work for Aramco although 31.3% of the sets are owned by Company employees. It could also be added that he is probably of the middle or upper middle class, which somewhat limits the health education potential; and yet it is probably this vigorous section of the population through whom the greatest advances in health education can be achieved.

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Learning to eat —the right way

Teaching a people to eat—the right way—is the task of Greenland's Nutrition Board.

Backed by a Nutrition Committee, the Board began its work in 1955 by carrying out an extensive survey of the nutrition habits of the population.

Various measures were then taken to improve the foods eaten, such as the enrichment of all flour shipped to Greenland, of powdered milk and of mashed potato powder. In addition, dried milk was distributed free to all pregnant women and nursing mothers. At schools however, at the suggestion of the Board, an attempt was made to introduce cheese instead of milk as a distribution project. Inaugurally, the cheese was given daily to boarding school pupils, to children in institutions and to patients in hospitals and sanatoria. If the children and hospitalised patients acquire the habit of cheese eating, the scheme will be launched further and extended to all Greenland's schools.

Parallel to these practical measures, the Board undertook an educational campaign bringing simultaneously into play lectures, posters pamphlets, radio broadcasts and the love of children for puppets. The plan called for emphasis on a new theme each month: " The Six Pillars of the Right Diet "; " Take Care of your Teeth "; " Sugar and Sweets are not Food ", etc.

The posters were hung in public places, such as hospitals, dental clinics, shops, factories, schools, etc.; the pamphlets, containing popular information easily understood by the public, were distributed through the same channels, while lectures on the same subject were given by medical officers and teachers.

Two posters " Clean Habits in a Clean Kitchen " and " Milk for the Mother is Necessary " were given to every household, plus another poster on the correct preparation of milk from dried milk. One of the themes particularly stressed concerned the dangers of eating too much sugar, a serious problem in all Greenland.

Following example from the experience of FAO which showed that children can successfully be influenced by information imparted through plays, all schools in towns and at large trading centres as well as children's sanatoria, received a trunk each containing props for puppet shows dealing with nutrition, dental hygiene, etc. The shows were first played to the children by the teachers, then by the children themselves, and soon these were on the road to improvisation.

Radio Greenland also broadcast about 100 two-minute " diet " flashes received from the Danish National Council of Domestic Science.

Latest projects: the publication of a cooking book on " What Every Housewife Ought to Know ", complete with dietary tables and flannelgraphs, and another series of radio lectures.

Enthusiasm and goodwill may be indispensable to the success of health education. They are not enough. Systematic and intelligent planning is also needed. This means that we should: a) find out what the health workers consider as the main local health problems, b) explore community feelings on the subject, c) establish the objectives of the health education programme on the basis of these findings, d) determine evaluation procedures to be followed and e) choose the best methods after careful pretesting.

The importance of programme planning

by Guy Steuart

This programme was carried out jointly by a team of four South Africans: the author; Joseph Francis, Supervisor of programmes for Indian communities; Christine Meintjies, member of the evaluation section; and Salatchie Naidoo, health educator. For the past five years, members of this team have worked together at the Institute of Family and Community Health in Durban, the latter three now being among South Africa's first health workers having specialised in health education and oficially recognised as "health educators".

"We need from time to time to take a look at the things that go without saying to see if they are still going" Carl Becker.

It is, perhaps, a major fault of many community health programmes, that they suffer for lack of adequate planning. In talking about planning, however, it is frequently hard to avoid the obvious. But it is this very feature which so often deludes us into believing that because we take it for granted, it is being done, or that since it is palpable, it is adequate.

This is a matter of paramount concern to health education and to the whole sphere of health and medical services of which it is part, vitally affecting the efficiency and economy of our efforts.

Preliminary exploration may be an intricate and lengthy process, and we may reject it on the grounds that we want to "get on with the job" either because we feel we have to put on an appearance of doing so, or because we are confident in our ability to produce change.

Such an approach is of course based on the fallacy that detailed planning is not really part of the programme at all and that the longer we take over it, the longer is educational action delayed.

Planning however, should not be considered simply as a prelude to educational action, although it does play a vital role in this respect. Not only does it have its own educational implications, it is also a process that continues through all action phases, making a total programme more purposeful, giving it a greater direction,

increasing its amenability to control, and yielding a clearer vision of its effectiveness.

The more dynamic aspects of planning, particularly the meaning with which it endows a programme for those participating, and the nature and quality of this participation, have been described by Nyswander [1]. To use her neat contrast, she was concerned mainly with the process rather than the procedures of planning. Here, on the other hand, an attempt will be made to review some of the procedures rather than the process.

The objectives, evaluation and methods

Planning may be considered to have at least three main aspects. These are characteristic not only of the preliminary phases but indeed of a programme as a whole. They consist of the definition of objectives, the design of programme evaluation procedures, and the determination of methods to achieve these objectives.

It is useful to think of these three aspects as at once intimately interdependent, as well as flowing most easily from one another in precisely this order during the preliminary planning phase. If objectives are adequately defined, the techniques for measuring the effectiveness of the programme in achieving these objectives emerge directly from them. Finally, it is apparent that the selection of methods must be dominated by their suitability for reaching certain results if they are not to become simply directionless activity pursued for its own sake.

In the key decision of what the programme objectives are to be there lies a double consideration. The objectives depend not on an expert or technical opinion alone. They have to be based not simply on what health and medical workers feel the community needs but also on what the community itself feels it needs. We have therefore both an expert and a community consultation to carry out. Knutson [2] has given an excellent account of the dimensions of this problem while Katsunuma [3] has recently described a preliminary examination of community attitudes in relation to the specific problem of trachoma near Tokyo.

The final definition of objectives consists of a precise statement of the aims in a form which is as far as possible measurable. The expert team will always retain to some extent its own evaluation scheme but even in this phase, community participation as far as possible is desirable. When community leaders and others offer formal support and identify themselves with the programme, they need to participate also in examining the success of their efforts for their morale will be deeply affected if they can see the fruitfulness of their own activity.

In selecting those methods which will most effectively achieve the objectives, we become involved in an exploration similar to that required in determining these objectives in the first place. For we are rarely if ever in a situation where, as with the audience in a lecture room,

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Born in Durban, South Africa, Guy W. Steuart received his education at the University of Natal and in 1952-53 attended the Yale University Department of Public Health. Originally a school-teacher, he later became clinical psychologist to the Institute of Family and Community Health in his home city.

With an increasing interest in health education, he eventually devoted his full time to this field. Among other projects, he was associated with the first systematic course in health education, through the 3 final years of study, for undergraduate medical students in South Africa, as well as with the training of the first health educators officially designated as such by the Province of Natal.

Guy Steuart is now on a W.H.O. assignment to Israel as Visiting Professor of Health Education at the Hebrew University Hadassah Medical School in Jerusalem.

His favourite pastimes are sea-fishing and swimming.

we are the only communicators with the audience in the role of communicant. Many programmes do of course, simulate this situation very closely, having perhaps impressive resources of mass media in the form of films, radio, press, pamphlets and exhibits. But where a programme has nothing more than this, the fundamental fact is being neglected that the community is not a mere aggregate of people passively recipient of any message conveyed attractively and insistently enough. It is rather a dynamic network of human relationships and communication channels, made up of a variety of social groupings which in turn consist of numbers of individuals each playing different roles of educational significance.

It is onto such forces that our health education programmes need to be grafted for the community is a vast self-educating mechanism, and the choice of which individuals and groups to influence, is as vital a decision as in what way we wish to influence them.

The staff states its views

To illustrate these principles in action a description will be presented of the health education aspect of a programme at present being conducted at the Institute of Family and Community Health at Durban by a mixed professional team of physicians, nurses, health educators and health recorders. This programme concerns antenatal and maternity care in Lakeside, a South African Indian community.

The " expert consultation " with physician and nurse was the first step. The physicians stressed the need to reduce, not only infant mortality as a whole but particularly perinatal mortality in the community and prematurity was mentioned as a major associated problem. An important feature was the fact that existing antenatal and maternity services were not put to the best use. In Lakeside, for example, women who had reared children sucessfully in the past were particularly inclined to regard antenatal care as unnecessary and inadequately trained private midwives enjoyed a considerable popularity.

To make an impact on the problem, there was a need for greater use to be made of skilled as against unskilled care both for the antenatal period and for the delivery of the baby, for first attendance to be as early in the pregnancy as possible, and for subsequent regularity of attendance at the normal recommended intervals, when ill or when special appointments were made.

The nurses further elaborated the picture when they suggested that the semi-trained local midwives were popular because they followed the customary rituals associated with birth and did the " dirty work " such as washing soiled linen. Mothers they felt, were generally unaware of the significance of certain aspects of nutrition on foetal, infant and maternal health. The feature of the skilled antenatal examination by which mothers were most impressed, was palpation which seemed to have an obviously useful purpose in detecting the lie of the baby.

But the nurses thought too, that antenatal sessions would be better attended if they were held at accessible sub-centres in Lakeside itself.

Finally consultation with the recorders yielded useful statistical evidence of the problem. For 1955, the Lakeside infant mortality rate was 43, its neonatal mortality rate being 24 and its post-neonatal rate being 19, all calculated per 1000 live births. For the same period, the stillbirth * rate was 28. Perinatal mortality

* Stillbirth counted as birth after 28th week of pregnancy and the rate calculated per 1000 births (live births and stillbirths).

was clearly therefore, at least proportionately, a major problem. So far as antenatal care was concerned, of 320 pregnancies in 1955, 54% had received skilled antenatal care. Of these, the mean stage of pregnancy at first attendance was 22 weeks, with a mean attendance of 4.5 times.

Records were available, of 213 babies delivered and of these 42% had skilled delivery, 38% semi-skilled by the traditional midwife and 16% unskilled deliveries mainly by technically unqualified midwives, the remaining 4% being unknown.

What the community feels

What then was the counterpart for these " expert " views in the community itself?

In order to test these feelings at the most fundamental level, the health educator approached certain selected primary informal groups of friends and neighbours in Lakeside. These groups had been detected by the use of simple sociometric techniques and varied in size from 3 to 8 women. There were 18 such primary groups consulted. Each primary group met in the home of the woman judged to be the most influential of her group and the discussion was introduced by asking what it was they wanted of an antenatal and maternity service and what they thought of the existing services.

In the intimate informal atmosphere of these groups, a strong feeling was expressed throughout in favour of the traditional semi-skilled midwife. Confirming the viewpoint of the Institute's nurses, people favoured these midwives because they carried out all the essential rituals concerned with childbirth such as the burying of the placenta, rubbing mustard oil on the baby to " give it strength " and conducting the ritual bath on the 3rd and 10th days after birth.

There was an acceptance of a limited amount of antenatal care by the physician but there seemed to be a general feeling that the doctor was of main value when the expectant mother was ill or experiencing pain. His care was not really necessary if one had one or more satisfactory births in the past. One point of his examination that was expressly mentioned was that of taking a blood specimen for laboratory tests. Mothers felt there was something wrong with taking part of this vital fluid which they believed could not be replaced. It appeared too, that the person who had most influence in determining which particular services the mother used, was her husband.

In addition to these private friendship groups, the health educator met the representatives of certain formal organizations in Lakeside. The persons interviewed consisted almost exclusively of men. They too expressed their favourable attitude towards the traditional midwife though they seemed to feel that all the services available were fulfilling a useful role and that skilled antenatal care was of value although they were not entirely aware of the reasons why it was important. They accepted that the situation could be improved if antenatal sub-centres were set up in Lakeside itself thus making the service more accessible and volunteered their help in finding accommodation for these to function.

This exploration of public opinion was, of course, largely of a qualitative nature and it was decided to make a systematic survey of some of the points raised by both primary and secondary groups so that a quantitative picture could be obtained of how widespread these opinions were.

A random sample of 223 women were interviewed in their homes. The analysis of the findings are not presented in full, but among the more interesting ones was the fact that marked majorities expressed

the opinion that a medical examination was really necessary only shortly before full term (79%), and that expectant mothers do not need medical advice about diet (77%). That abortions and stillbirths were caused by evil spirits was believed by 34% of the women who also felt that a priest should be consulted during pregnancy. The antenatal examination itself described as an unpleasant experience by 37%. A strong preference for delivery at home rather than in hospital (66%) was expressed and that the traditional midwife was best (45%). The husband's advice was the main single determinant (26%) of which services were used.

In this picture of the preliminary exploration of community feeling, the obstacles have been stressed largely because it is when such obstacles as these lie concealed that eventual poor results may occur. But we have not presented all the favourable findings. Lakside community lays great stress on infant care and there is a very favourable feeling towards the Institute services and its staff. People may use traditional midwives, carry out certain rituals, or consult priests but they are also relatively discerning users of skilled medical services at the same time. Thus although recognizing the obstacles to succeess, it was felt that a carefully conducted programme could produce results.

The final decision on objectives

With the exploratory phases complete, the objectives of the programme were now designed and stated. The master objective was the reduction of foetal and neonatal mortality rates in Lakeside. The subsidiary objectives were to increase the proportion of expectant mothers making use of skilled antenatal care, to encourage their attendance for the first time at an earlier stage of pregnancy and with the recommended frequency, and finally to increase the proportion of expectant mothers making use of skilled maternity services for delivery. *

The evaluation of programme success would then be based on measures of the stillbirth and neonatal mortality rates calculated for each year of the programme, and four monthly analysis of records concerned with the subsidiary objectives. It was also decided to repeat the quantitative opinion survey 8 months after the start of the programme.

At the same time, it was felt that control measures would also be useful. Thus, the educational campaign was to be conducted for four successive months in Lakeside North and then in Lakeside South alternately, these two areas dividing Lakeside into two roughly equal parts. All measures of subsidiary objectives would be done for Lakeside North and South separately, thus offering some opportunity of comparing the effect of an active programme in one area against a relative absence of programme in the other.

Choosing the methods

The last major issue in the pre-action planning consisted in deciding what methods were to be used in the programme.

At the individual level, it was decided that the "key" persons should be met prior to group discussion or the use of mass media, to test their feelings about the programme as a whole and to hear their suggestions.

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* An essential inclusion would have been an attempt to have improved technical training for the traditional midwife who, in fact, already had a partial training. But certain local complications precluded such an objective at this particular stage.

The method to be used with primary groups was given a trial run with six selected primary groups, three of them with members having a more traditional outlook and three with members of a more Western viewpoint. The first trial run, with all six groups, in the shape of informal discussion with group decisions, showed that too much emphasis was laid on Western style services and that this tended to arouse a correspondingly stronger resistance, and encouraged marked expressions in favour of the traditional midwife.

At the same time, a flannelgraph, flipbook and model of a foetus in the uterus were used to illustrate various antenatal and maternity care procedures.

Following two trial runs, it was agreed that the topic should be introduced to primary groups in the form of an enquiry as to what kind of care the group felt was necessary for pregnancy and delivery. Thus it would not be led to make a direct comparison of the traditional midwife with what the expert called a "skilled" person. This, it was apparent would be likely to cause a feeling of open conflict, with a probable final decision in favour of the traditional midwife. The aim during the discussion would be to have the group reach four decisions corresponding to the subsidiary objectives.

With secondary groups, a similar kind of approach was to be used and attempts made to encourage action that would result in the establishment of field antenatal sessions. These secondary groups would be a valuable route for reaching men.

Special records forms were designed for completion after every group contact, whatever kind of goup it was.

The personal face-to-face, primary group and secondary group education was to be supplemented with the use of mass media. These were to consist of previously pretested films and exhibits. Personal invitations would be sent both to the recognized leaders of organizations as well as to the apparently private people who in everyday life seem to affect the outlook, opinions and behaviour of their personal circle of friends and acquaintances.

The role of doctors and nurses

Orientation of the staff would consist of discussions with medical and nursing personnel in respect to their roles in the programme. The physician and nurse in clinical, home visit and group situations (such as at antenatal sessions) were to initiate discussion and community education. It was important that the patient at the time of experiencing care should appreciate why certain procedures were carried out. The nurse particularly was to be given experience in conducting group discussions. *(Continued next page)*

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Conclusion

This then illustrates some aspects of preliminary planning in a particular health education programme. This is not a comprehensive picture but it was hoped to illustrate something of the complexity of planning procedures.

To achieve some order out of this complexity and at the same time to prevent neglect of basic procedures desirable for success, use is made of a programme planning guide. This is the pilot record in the files of each programme. It takes the form of a check sheet on which the main procedures are listed and the health educator in charge of that programme is able systematically to mark them off as they are completed and to see at a glance what stage he has reached.

Although this is a purely mechanical affair, it is not necessarily to be scorned. Programme planning is still not itself a mechanical procedure but one of great richness and flexibility. Indeed its very complexity may sometimes paralyze action.

At the one extreme, some programmes accept loosely defined objectives and go into action on a broad canvas without more ado. At the other extreme, preliminary investigation may be carried to such lengths that the richness of the material yielded has the effect of postponing precise, well-directed action, because somehow the direction to be taken has lost its identity in an intricacy of community cultural patterns of thought, feeling and behaviour.

Thus we need to have a clear recognition not only of the variety and new possibilities that appear with each programme but also of the relatively stable elements out of which effective planning is built, for health education in action is both art and science.

USSR: the health of

The development of health education in industrial areas to reduce morbidity and accidents among workers was the theme of the end-of-the-year session of the USSR Council for Health Education. The Council convened for three days at Sverdlovsk, in the Ural, and was attended by more than 160 health educators, mass organization representatives, factory directors and head engineers.

Many of Sverdlovsk's doctors and scientists took part in the meetings during which 12 papers were read on the following subjects: industrial health, the integration of health education in the professional training of workers, health education through mass media.

As the improvement of work conditions is ever closely linked to health standards, the emphasis of the talks bore on measures for the perfecting of air conditioning in workshops, the mechanization of production, the wider utilization of water pulverization and dust absorbtion mechanisms in mines, together with the installation of modern showers, women's rest rooms and the rational planning of meals during working hours.

Every industrial concern of any importance organizes advanced professional courses for workers and foremen. These courses also include health instruction. Speakers therefore stressed the need to develop such programmes and to adapt them more closely to the technologies and specific factory needs. They also insisted on the good influence of five to ten day

of the workers

by Ludmilla Bogolepova
Moscow Central Institute for Health Education

courses for new workers, to introduce them to safety and health problems.

Both reports and discussions dealt at length with education methods for large factories and workers' cities. Health " days ", " months ", " weeks ", as well as " best workshop contests " are held on a large scale.

These campaigns keep workers, foremen and technicians alive to the need for healthful working conditions and bring excellent results. They also have the full support of the families concerned.

Much progress has indeed been achieved in the prevention of disease and accidents whenever the measures taken by public authorities have been backed by the workers and by social organizations.

For instance in 1958 the number of work accidents registered by the metallurgic concerns of the Sverdlovsk region was 20% to 30% lower than in 1957. Ventilation improvements in the workshops reduced sickness cases due to colds by 11%, while the number of working days lost through such illness was 16.3% lower. Improved environmental hygiene in factories and workers' cities and the development of health knowledge among the population, also reduced the frequency of gastro-intestinal disorders and the number of working days lost decreased accordingly by 12% and 14% respectively.

The delegate from Tcheliabinsk stated that action taken by mass organizations, contests for the best workshop and educational measures had resulted in a decrease of the morbidity rate among workers. He quoted as an example a metallurgic factory which could boast of a decrease of 18% in purulent dermatosis cases, of 37% in cases of sickness due to colds and of 50% in accident rates.

After the meeting the participants decided to make the result of their discussion known to all health education personnel, trade unions and to the Red Cross.

The closing session was devoted to a discussion on the following problems :

1. the organization of health education in the USSR
2. the planning of health education
3. the training of specialists.

This discussion had been planned, as had the meetings held in Moscow and Leningrad, in view of the XIIth World Health Assembly whose Technical Discussions will be devoted to the health education of the public.

The Red Cross is actively associated with the protection of the health of workers in the USSR

panorama

The general headquarters of WHO have been busy during the past months with preparations for the World Health Assembly and its technical discussions which will feature this year health education of the public.

Technical discussions were started with the Fourth World Health Assembly in 1951, to enable participants to devote particular attention to a few programme subjects each year. Since then, members of government delegations from all parts of the world who meet each year for the World Health Assembly have had the opportunity to talk over some of their problems during informal sessions, i.e. training of public health personnel, the economic value of preventive medicine, control of tuberculosis, syphilis and typhoid group of fevers, public health problems in rural areas, the education and role of nurses and the role of the hospital in public health programmes.

As a first step towards preparation of the technical discussions on health education, which will take place in Geneva, 12-13 May, an outline for preliminary discussions was sent out by WHO in March 1958 to Governments and Non-Governmental Organizations —such as the IUHEP—asking them to review their health education progress, preparations and future plans. This has resulted in reports being received from 58 countries and many organizations. Summaries and quotations from these various reports—covering the areas of planning, organization and administration of services, training, research and studies in health education—have been culled in a background document which will serve as a basis for the 1959 discussions.

Significant of the interest aroused by this theme is the fact reported by certain governments that up to 30 meetings of health workers had been held at national and regional levels, to discuss the WHO outline and present specific information about their health education programmes.

It is expected that over 80 countries and many observers from NGOs will take part in the technical discussions, whose Chairman was designated last year by the World Health Assembly in the person of Sir Arcot Mudaliar, from India.

The programme will be opened by a symposium presented by a group drawn from delegates and representing different interests. Participants will then break up into fifteen discussion groups, to consider the four main issues raised in the basic WHO outline. Special features of the meeting will be a demonstration of health education techniques by Dr W. Emrys Davies, from the United Kingdom, and an exhibition illustrating some basic health education principles such as health education is every health worker's business, how do people learn about health, health education is part of all public health programmes, health education needs research, health education needs trained workers, health education needs good tools. The reports sent in by countries will also be on display, together with important journals and publications on health education.

A report of the discussions, in the form of a panel presentation, will be given on the following Wednesday to the World Health Assembly.

All WHO regional health education advisers will attend the technical discussions and hold a meeting, 17-25 May, to discuss problems of mutual interest concerning the development of health education in the various areas of the world.

IUHEP news

BEIRUT — Preparatory work for the establishment of a National Health Education Committee has been undertaken under the leadership of Prof. Louftalha Melki.

BUENOS-AIRES — A provisional National Committee for Health Education has been founded on the initiative of the Argentine Cancer League.

BUCAREST — The Health Education Committee of the Rumanian Red Cross has asked to become an active member of the Union.

LUXEMBURG — The Luxemburg Society of Health has asked for admission as an active member of the Union.

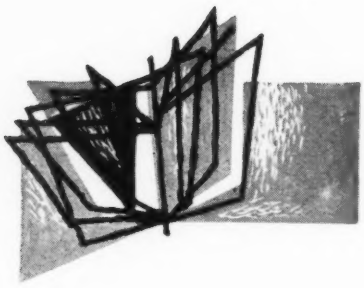
PARIS — The Gold Medal of the French Academy of Medicine has been awarded to Professor C. E. Turner, chief Counselor of the IUHEP, for his leading contribution to the advancement of health education.

NEW DELHI — Princess Amrit Kaur, former Indian Minister of Health, has accepted the post of Vice President of IUHEP for South East Asia.

RIO DE JANEIRO — Plans for the founding of a National Health Education Committee are rapidly advancing under the leadership of Dr L. C. de Brito-Bartos, Health Education Director of the Brazilian Ministry of Public Health.

WARSAW — The Health Education Committee of the Polish Health Society has applied for membership in the Union.

books



Health Education Monographs

Society of Public Health Educators, Office of Monograph Committee, 121 East 11th Street, Oakland 6, California; 1958, 32 pp. Price: $1.00 (cheques should be made to Health Education Monographs).

In the second of its series of Health Education Monographs, SOPHE presents two articles on research findings about the application of social science to health education.

In *Perception and Public Health*, Gordon Allport raises the question: "Does the receiver hear and comprehend the health message as the health educator intends?" In a brilliant exposé of barriers to reception —"we sense what the outer world offers... through social and personal lenses..."—the author traces contacts between perceptual research and public health work. "The point I am trying to make is that the health worker cannot overlook the dynamic propulsion that causes one individual to accentuate, another to reject, and a third to distort the health message that is offered. Its reception will vary according to the nationality, the class membership, the ethnic group, and above all, the personality and present situation of the client." To fix attention upon "this variable of prime importance" the author proposes a new concept: *proception.*"

Stressing how hard it is to know how to present our invitation to learning to students or clients because of their own *proceptive* directions, he concludes: "This modern challenge to public health is no doubt the most difficult it has ever had to face. The comfort I offer is that the researches of social and psychological science will increasingly provide strategic aid, especially perhaps its discoveries concerning the logic of *percepts* and of *procepts.*"

The Health Officer and Community Power Groups, by Julius S. Prince, describes a portion of a study in which the author adapted "some of the methods already tried and tested by social scientists to the peculiar needs of the practice of public health".

What are the power groups and power individuals in the community, what are their attitudes towards some of the existing and proposed public health programmes? "...By using relatively straightforward social science and statistical technics, an attempt is made to delineate differences in attitudes and opinions towards public health on the part of the community's power groups and on the part of a representative sample of its total adult population."

This is a most stimulating report on how to conduct community enquiries—a subject of primary concern to all health workers.

Second European Conference on Health Education of the Public

by the Regional Office for Europe, World Health Organization, Copenhagen, 1959, 68 pages.

The Second European Conference on Health Education of the Public was held in Wiesbaden, Germany, from 27 June to 5 July, 1958, under the sponsorship of the WHO Regional Office for Europe with the Ministry

of the Interior of the Federal Republic of Germany. The purpose of the Conference was to explore what needs existed and what programmes and facilities were required for the training of physicians, nurses and other health workers in health education of the public.

Fifty-five people from 21 countries took part in this meeting which was planned so as to give maximum opportunity for informal study of training requirements during plenary sessions as well as in small group discussions. The report presents the various papers read at the conference and the conclusions of the professional and inter-professional discussion groups on health education training in medical education, for nurses and for public health workers.

Getting Community Action

by the Massachusetts Public Health Association (Health Education Section), the New England Health Education Association, and the Massachusetts Department of Public Health, 1958, 60 pages, $1.00 post paid.

This is a detailed report of a two-day training work-conference for sixty New England health educators on "Getting Community Action". Practical application of social science theory and research in how to get health programmes across to the community and how to work effectively with groups was the focus of this intensive work-conference.

Of particular interest to those who plan to undertake similar training ventures are: (1) the three-page chronology describing the conferences, planning sessions, polling of members and other activities prerequisite to realization of the conference itself; and (2) the comprehensive appendix of widely varied materials developed during the planning and conduct of the conference. The latter includes the programme announcement, questionnaires for polling participants on suggested programme content, forms for conference evaluation, schedules, and descriptions of the community issue, together with individual role playing briefings, guide for historian-observers, and evaluation summaries of participants.

The report is available through the Division of Health Information, Massachusetts Department of Public Health, State House, Boston 33, Massachusetts, U.S.A. Please make cheques or money order payable to the New England Health Education Association. C. F. D.

School Health Programme

by Jesse Helen Haag, Ed. D., Henry Holt & Co., New York, 1958, 533 pages, $6.50.

This presentation of the school health programme is written primarily for the teacher. Its comprehensive coverage is organized in the form of eight parts dealing respectively with health services, safe and healthful school environment, school nutrition, community resources, health of school personnel, school day and its relationship to the pupil's total health, health and safety instruction, and organization and administration of the school health programme.

The book presents a considerable amount of health subject matter in nutrition, dental health, safety, communicable disease, physical defects and other areas along with suggested teaching method and administrative perspective. M. F.

Problems in International Health Programs

by George M. Foster, Social Science Research Council, 230 Park Ave., New York, 1958, 49 pages, $.50.

This pamphlet outlines the human and social problems encountered in intercultural health programme concerned with "the formal, planned interchange of medical and associated ideas and practices across cultural and subcultural boundaries, and sets of interpersonal relationships of many types between individuals and groups of individuals belonging to different cultures and subcultures." Foster discusses the cultural and social problems, as well as the categories of knowledge needed to solve them and how such knowledge may be used in a public health programme.

There is discussion of cultural barriers, motivations to change, and the role of the

social scientist. As for cultural barriers, consideration is given to suspicion of new things, fatalism, modesty, the religious factor, social structure, family structure, suspicion of government programmes and personnel, problems of communication, problems of perception, faulty technics, and differing expectations. Motivations to change include prestige, perception of economic advantage, competition, the desire to do what is forbidden, play, and authority.

This is a pamphlet needed by those in public health. It is of special value to health educators, for it considers the change factors and barriers commonly experienced in health education activities. M. F.

It Happened to Me

A story told in pictures by Gordon Boshell, World Health Organization, South-East Regional Office, Orient Longmans Private Ltd., 17 Chittaranjan Avenue, Calcutta 13, 1958, 36 pages, Rs. 2.50.

" My mother was a midwife in our village. She learned her craft from her mother. She has never had any proper training and had never been to school. Such untrained midwives are called *dais* in my country. But my mother made me go to school. And when I passed my final examination, mother went to the house of her friend, Lakshmibai, to tell her the good news... " *It happened to Me* is the story of a mother and daughter who answered the call to become trained health workers, so vitally needed in India and indeed throughout South East Asia. At the outset they faced opposition and mistrust but in the end a whole village was won over to the cause of health. Brief captions accompany the fifty-three striking pictures which illustrate this human interest story.

Current Bibliography on Research in Health Education

In the July 1958 issue a partial current bibliography of research studies in health education was published. Since then six additional published studies have been reported to the Committee on Research. In addition, a number of mimeographed reports of research have been uncovered. References are given on those studies, where a definite source for obtaining the report can be stated.

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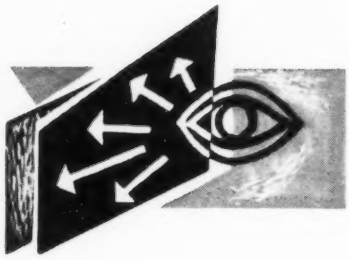
films & visual aids



One Day's Poison

30 min., 16 mm., black and white, sound (English), 1958; National Film Board of Canada, Toronto, or 680 Fifth Avenue, New York, N. Y.

This is about the work of the Poison Control Centre at the Toronto Sick Children's Hospital. Several dramatized incidents illustrate the variety and number of accidental poisonings among children. They support an attending physician's contention that "accidental poisoning kills more children under six years of age than all the infectious diseases combined". The films begins in a home with small children and parental carelessness or lack of precaution responsible for this high percentage is shown.

The film is an indictment against the adult neglect or carelessness that can exact such a tragic toll of innocent young life. To counterbalance it as far as humanly possible, poison control centres such as the one in Toronto are on duty day and night, giving advice by telephone, treating cases brought in, waging a never-ending fight to save the victims of needless accidents.

Of wide interest, with special value for parent education and health programmes.

Going to Hospital with Mother

45 min., 16 mm., sound (English).
Rental $10.00 a day; sale : $150.00 (Guide); Tavistock Institute of Human Relations, Child Development Research Unit, London, England.
Available also from the New York University Film Library, 26 Washington Place, New York 3, N. Y.

The greatest single cause of distress in young children in hospitals is not illness or pain but separation from the mother. Unable to understand the necessity for her absence, the child frequently becomes emotionally disturbed. Even after a brief hospital stay, such behaviour may persist upon his return.

Ideally, therefore, if a young child is hospitalized, his mother should be admitted with him to prevent distress of separation and to help in his care. This film shows how the staff of a British hospital has improvised a method of routinely admitting the mothers of patients under school age to a ward of traditional design without structural alterations. We are shown that ordinary mothers, when given a positive role in the care of their sick children, are generally as adequate in the ward as in their own homes. The film follows the experience of Sally, aged twenty months, and her mother as well as other mothers in residence and shows how adequately this method of care meets the emotional needs of the young child, contributes to the mother's high morale, and enriches the experience of the staff. The fact that this method has its own problems is not overlooked.

Bitter Welcome

36 min., 16 mm. black and white, sound (English), 1958; Mental Health Film Board, 267 W. 25th Street, New York, N. Y. Price $145.00.

This is a film about the struggle of the discharged Mental Hospital patient to overcome the fears and prejudices of his fellow workers and to regain his place in the community. It shows his painful efforts of readjustment when he is rejected by the men on the job. It exposes his feelings of conflict, torn between belief that his wife loves him, and fear that she only pities him. It

dramatizes his courage and perseverance as he battles to keep his job, his home and his own confidence.

The purposes of *Bitter Welcome* 'are : To allay the fear and suspicion that prevail in many communities, as a result of larger numbers of patients being discharged due to new drugs and improved therapies.

To help toward total rehabilitation of the increased number of patients being released today, by changing attitudes of members of their families, fellow-workers and employers.

To dramatize the fact that mental illness can and is being cured, and that former patients can function as responsible members of family and community.

A Place to Live

24 min., 16 mm., black and white, sound (English);
The Wm. S. Merrell Company, Medical Audio Visual Dept., Cincinnati 15, Ohio. (Please give a first and second choice of showing date.) No rental charge.

Findings are based on a three-year study by the National Social Welfare Assembly who provided background for this film about homes for the aged. A *Place to Live* is exceptional (winner at Edinburgh Film Festival) because it honestly portrays some of the problems of old age. It is a picture within the bounds of actuality. Suitable for lay audiences.

Heart Disease and Dentistry

30 min., 16 mm., black and white, sound (English); Schering Corporation, Bloomfield, New Jersey. No rental charge

A pictural explanation of the possible relationship of foods, fat and heart disease is explored here as well as a presentation on the subject of dentistry. Suitable for civic organizations, service clubs, high school science students and other lay audiences.

Helping Hands for Julie

25 min., 16 mm., black and white, sound (English); E. R. Squibb & Sons, Div. of Olin-Mathieson Chemical Corp., 745 Fifth Avenue, New York 22, N. Y. No rental charge.

Attempts to attract students into careers in medicine and health by dramatizing their opportunities. The story revolves around the fight for life of a little girl who is brought into a hospital emergency room in a perilously sick condition. Through the help of the entire hospital medical team she is brought back to health. This film shows the pharmacist as an integral part of the hospital medical team. Suitable for all types of lay audiences, particularly those of high school age.

Human Speech

30 min., 16 mm., black and white, sound (English); Schering Corporation, Bloomfield, New Jersey. No rental charge.

Mechanisms of human speech, a presentation of how speech is produced without vocal cords, and a segment on pathology comprise this interesting half-hour. Suitable for civic organizations, service clubs, high school science students and other lay audiences.

The Valiant Heart

27 min., 16 mm., black and white, sound (English), E. R. Squibb and Sons, Div., of Olin-Mathieson Chemical Corp., 747 Fifth Avenue, New York, 22, N. Y. No rental charge.

One of a family of five children becomes ill with rheumatic fever two weeks after suffering an untreated " strep sore throat. " It shows how prompt action by the family doctor and modern advances in medical knowledge concerning the disease, give the boy a good chance of recovery with little or no heart damage. It explains how preventive measures will be employed to protect the patient against future " strep " infections and thus against further attacks of rheumatic fever. Suitable for all adult lay audience groups.

These films have been reviewed by MOREY FIELDS

Ligne de vie

16 mm., colour, sound (French), 19 minutes, 1958; Centre national d'Education sanitaire démographique et sociale, 92, rue Saint-Denis, Paris 1er.

This film is a chronicle of the first years of marriage of a young couple, Nicole and Pierre. It is, therefore, a love story—a film

as resfreshing as spring. The events of this chronicle are made of the daily happenings: Nicole is a typist and Pierre is employed in a large public works department. Very quickly, however, with the news of a birth, the chronicle becomes that of the baby to be born and then of the baby itself.

The real subject of the film is mother and child health. No technical words are used. Only short scenes which give as many examples of the rules to follow and the means available to protect the health of the mother and her child.

Revivre

16 mm., colour, sound (French), 28 minutes, 1958; Centre national d'Education sanitaire démographique et sociale, 92, rue Saint-Denis, Paris 1er.

Happiness is an art, and one needs much talent to be happy... This young woman, a commercial secretary, is happy. This florist is happy. This photographer-reporter is also happy. And yet, three years ago... Three years ago, at the clinic or at their doctor's one day they had the revelation of their disease: tuberculosis. A long stay in a sanitorium... The discouragement... The worry about the future... Then new hope comes to them as they are directed towards a rehabilitation centre where they learn a new profession. They will come out cured and better armed for daily life.

Assisted by the directors, teachers and instructors of the rehabilitation centre, they have entered « a new life ».

Des enfants comme les autres

16 mm., colour, sound (French), 22 minutes, 1958; Centre national d'Education sanitaire démographique et sociale, 92 rue Saint-Denis, Paris 1er.

Danielle's mother tells the story of her six-year-old daughter. In the class Danielle is absent-minded, a bad pupil. At home, she is « as good as gold ».

This mysterious behaviour is explained when the child undergoes a medical examination at school. Her mother learns from the doctor that Danielle suffers from strong myopia. She is an « amblyope » and the ophthalmologist advises to send her to a special school.

This school is very pleasant and the pupils are happy, without complexes. Special teaching methods enable them to follow easily the school programme. The school even goes further: it prepares the children for life and tries to give them a place in society. Professional orientation tests determine the children's aptitudes and in their last school year, they learn a profession.

They have become « children like the others ».

Vertiges

16 mm., black and white, sound (French), 29 minutes, 1958; produced by J. K. Raymond-Millet Films for the Centre national d'Education sanitaire démographique et sociale, 92 rue Saint-Denis, Paris 1er.

The purpose of the film is to show through varied examples—which can reflect only in part thousands of more complex cases—how modern life, overwork and excesses can, under certain conditions, bring close to madness men of all social classes, in appearance very healthy and sane.

In each case, the film shows how the patient came to consult a psychiatrist and was comforted, « relaxed », and how he revealed his secret after lengthy interviewing, sometimes after several weeks of conversation and often without knowing it. It is this secret, hidden in the deepest part of his subconscious, which allows the psychiatrist to care for the patient and to bring him back to mental health and equilibrium.

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